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TABLE *of* CONTENTS

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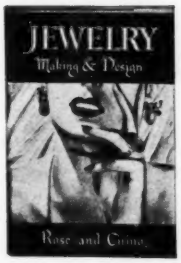

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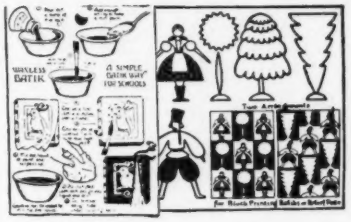

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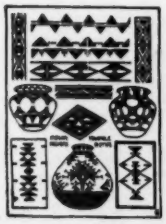

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Methods and Techniques Used in O.T. For the Imbecile

By MARIELLA MENZEL

Letchworth Village, New York

Occupational Therapy is one of the most valuable therapeutic measures available to children living in an institution. As an occupation, it can create in the individual, feelings of accomplishment, industry and satisfaction which, in turn, may lead to a better social adjustment. As therapy, it is remedial and informal, being specifically directed towards the interests and needs of the individual. The numerous activities provided in the Occupational Therapy class are so flexible and varied that the therapist generally can adapt them to the specific potentialities and aptitudes of the handicapped children. Thus, by substitution of constructive activity and satisfactory accomplishment for deadening monotony, we are able to counteract destructiveness, untidiness, and mental stagnation and so raise the morale of the entire institution.

Many patients are life-long residents of a State school. The lowest group of patients, the idiot, are vegetative so that custodial care is the simplest solution for the majority of them. All other groups of patients do fit into categories where occupational therapy can play an important role, particularly in handling the next higher group, the imbeciles. Although many patients of the imbecile group are dull, they are appreciative and a very definite development may be gained, if opportunities are given to them. By concentrated efforts their lives may be enriched and frequently even their I. Q. scores may be raised. In most instances deterioration may be prevented or deterred.

It has been demonstrated and it is well known that the imbecile is trainable, if the slight spark of any ability is discovered and cultivated. One of the finest Oriental rug makers at Letchworth Village has a mental age

of two and one-half years which would put this patient even amongst the idiots. In the group of successful bobbin lace makers we find M. A.'s as low as four years. This type of handwork requires a variety of intricate movements and also presupposes a high degree of manual dexterity, as well as the ability to reproduce a pattern with careful attention to details.

In view of the occurrence of such striking successes, we were at a loss to understand the high percentage of complete failures among our imbeciles. It is the therapy developed for this group of failures that I shall talk about.

Up to about five years ago we handled this group of children by what might be termed the orthodox method of teaching which, to be sure, works largely on the principle of the teacher trying to impose her *will* upon the pupil. The teacher plans the work and the pupil is supposed to execute it according to directions. In those days we could count roughly two-thirds failures and one-third successes. This large percentage of failures aroused in us some doubt about the adequacy of our methods. After having given special consideration to those failures, we arrived at methods that proved to be successful in numerous cases from the teaching standpoint. We work in the theory that the desire to express one's feeling and ideas in some material form is felt by almost every person including the feebleminded child. We also believe that there is little undertaken by a normal child that is not possible of accomplishment among the feebleminded, particularly in connection with manual efforts.

As far as the general characteristics of this group are concerned, the following might be stated. All of these patients had I. Q.'s not lower than 20 and not higher than 50. Their M. A.'s ranged from 2½ to 5 years at the beginning of the experiment. The youngest chronological age was 10 and the oldest 29. All patients had habit training prior to admission to occupational therapy. This study is based on experiences with girls only. A study of boys is contemplated later. Before they came to occupational therapy class, practically all of these patients had protracted periods of compulsory idleness which had deleterious effects upon them. Such patients necessarily must be confronted by the serious difficulty of adjusting themselves to the normal rhythm of regular work when they come to occupational therapy.

Many of these patients seem to lack normal stimulus from within and so they must be strongly encouraged to explore, investigate and later to experiment. The environmental stimulation, which is always a potent influence, is most essential in stirring an interest in the work. For this purpose the atmosphere of the occupational therapy room must be artistic, colorful and attractive. The handwork being exhibited should be creative and purposeful, so as to have an inspiring effect upon the patient and aid in the development of his creative faculties.

The importance of approaching these patients slowly cannot be over-emphasized. In order to alleviate an inferiority complex, considerable attention must be given to a gradual adjustment of the patient to this new endeavor. From the beginning every effort is made to establish the best possible rapport between child and therapist. This may consist merely of talking to the patient in order to give him time to get accustomed to the new environment and the ways of the therapist before any attempt is made to work with him directly. He should be exposed to the stimuli of the craft shop and allowed to wander around to satisfy his own curiosity in his own way without interference from the therapist who, meanwhile, notes any apparent interest either for work or for other patients. These notes will assist the therapist later in assigning jobs. This contact work between therapist and patient is most important. Often many days pass during which no response on the part of the patient is evidenced save for perhaps an occasional glance, but just such a little reaction has to be regarded as a genuine step forward.

When put to the task of learning, the imbecile patient may become irritable, may pout, or in other ways show a lack of emotional control. Such behavior must be interpreted by the therapist as due to lack of understanding on the part of the patient but by no means as a problem of censurable misbehavior or wil-

ful disobedience. Accordingly, every little progress should be rewarded with enthusiastic praise by the therapist in order to build up the self-confidence of the patient. Where the patient's mental poverty seems to circumvent any possibility of his learning, even the simplest tasks, endless repetition of teaching efforts on the part of the therapist will occasionally prove immensely rewarding. The imbecile patient is especially responsive to flattery such as, "You must be a bright child being sent to school by the doctor." This will make him feel important and he will usually try to do better work. He may attach himself to another patient after a few days or may ask whether he can undertake a certain job. When he does this on his own initiative much more has been accomplished than would have been gained by his labor in the few days "wasted." Some patients of this type work surreptitiously when they think that the therapist is not looking and it is usually better to humor them by not looking until they seek help.

It may be well at this point to enumerate the most distinctive qualities desirable in the therapist who deals with the mind of a mentally defective patient. First of all she must have patience and still more patience. Her activities must be unhurried and without urgency. The most hopeless lack of capabilities may often be overcome by dogged persistence in efforts towards improvement of the individual. In addition she must have the ability to adapt a sense of humor to the mental level of the patient. Furthermore, all her actions must reflect an interest in the patient. She must attempt a psychological interpretation of the child's behavior. To do this she must find answers to such questions as: Why does the child act this way; why is his attention span so limited; why does he day-dream; how can the aggressive-destructive tendencies be converted into constructive ones; how can interest, when it appears, be directed into useful channels. The answers to such questions must be found before actual therapy begins. Her approach and methods will have to be different for each child and only by experience in doing the work will she be able to vary her methods successfully. It should be unnecessary to point out that a therapist's personality can be seriously destructive to patients unless her attitude is right. The therapist, who becomes emotionally involved with her patients, is a liability. Consequently, the therapist herself must be reasonably well adjusted because her own personality enters greatly into the scheme of things and may be a therapeutic force, if she but knows how to use it. Tolerance, kindliness, and imagination are essential attributes, if success is to be attained. In addition, creativeness in the therapist is highly desirable as only a creative therapist will inspire the patient to create.

As it is an accepted point of view in the medical profession that left-handedness never should be reversed forcefully, we have adopted and extended this principle to cases which formerly failed on account of a forceful attempt to reverse the child's innate pattern. I should like to exemplify this point: A certain child was taught to do cross-stitches. This was to be done on stiff canvas with the holes marked for each stitch, making a series of half-stitches in one straight row upwards, and completing the row by making complementary half-stitches downwards. The child refused to work on vertical lines but rather insisted upon placing her stitches diagonally. All attempts to change her way met with failure. Therefore, we designed a pattern, adapted to this patient's way, i.e., diagonally through the canvas. By this strategem the child learned to perform her cross-stitches, not only diagonally, but also later in vertical and horizontal lines. According to all previous experience, this child never would have learned the stitch at all, had we insisted upon teaching her by the conventional method and had we not turned her mistakes to profitable account by change of our own technique.

If the patient does not succumb to the suggestive atmosphere of the occupational therapist shop after a time, the therapist might sit down beside him and show him how to do some simple work. She may put it in his hands and leave him alone with it for a while, then, if he does not continue to work, she may try directing the motions of his hands, provided this is not resented. Occasionally work therapy has to be postponed and play

therapy substituted, as this will utilize kinesthetic habits which in such cases lend themselves as most accessible starting points for work therapy yet to come. Early work therapy should be limited to projects that are short enough to insure completion within reasonable time. Consequently praise and approval should follow immediately. Furthermore, the work schedule should have frequent, natural breaks, so that each sector will keep the patient's attention with comparative ease, and provide a reprieve before more concentration is required.

Of course with each individual a different method of approach and technique might be required in order to reach inaccessible cases of the types to be described. A few complete case histories will serve to show how our techniques have functioned in the advancement of our therapeutic objects. Each of these illustrative cases presents some of the factors which were essential for successful treatment.

CASE 1

Lillie, age 30

Admitted to Letchworth Village 11-9-30

	C.A.	*M.A.*	*I.Q.*
	14.4	3.4	25
	17.2	3.10	24
	27	3.4	21
7-20-46	29.11	3.3	20

Lillie's case shows particularly well the therapeutic possibilities of occupational therapy for a low grade imbecile, with poor hereditary background.

Lillie's parents are Russian Jewish immigrants. Her mother worked in a shirt factory until she married at the age of 14 years. The mother has limited mentality, with slovenly habits, which makes her a very poor housekeeper. She also is easily excited and most unreasonable in all family matters. The father is referred to as a constitutional "psychopath."

The patient's birth was normal. She talked when 5 years of age and entered the first grade in the public school at the age of six, and remained in that class for six years. She has an organic speech defect.

Though the patient's behavior had always been good, she could not care for herself properly and was not able to learn in school. There was no one at home capable enough to care for her, so she was committed to Letchworth Village, 11-9-30.

Lillie was put in a low grade cottage and stayed there for four years, and in 1934 her physician sent her to occupational therapy for treatment.

The patient, an attractive girl, with sparkling brown eyes, and a pleasing personality, was liked by all from the very beginning. Lillie is a neat, quiet, affectionate, cheerful and well-mannered girl.

Lillie's adjustment period in occupational therapy was very slow. Not having had the right kind of training until the age of 18 years, this long period of compulsory idleness was beginning to have a deteriorating effect on the patient. She was confronted by many serious difficulties. She had a pronounced inferiority complex and no self confidence. She was easily discouraged, although she tried very hard and cooperated well with the therapist. Her hands would tremble and she would cry. Verbal explanations were absolutely useless. When something was explained to her, she would repeat the words the therapist used, but the blank expression on her face showed that she did not comprehend.

This babyish attitude slowed down the process of learning considerably when pre-kindergarten work, which it had been necessary to use at the beginning of the treatment, was put aside and work on textile fabrics begun.

Soft materials seemed to annoy Lillie. She would crumple them in her hands like a handkerchief. A stiff canvas with large holes was substituted and a big needle and heavy thread were used to teach her the most simple motion of operating a needle, by pulling the thread through the holes in a straight line across the material, technically known as a running stitch. As simple as it was, Lillie would go off her course and go zigzagging across the canvas and knot her threads. It seemed impossible for her to do and made her very discouraged.

Recalling the fact that small children learn by way of imitation and exercise, we tried this method. The therapist decided to sit with

the patient and actually take the patient's right hand in hers, insert the needle in the hole of the canvas, and had Lillie pull the needle through with her left hand. She learned the motion of the stitch until it became a mechanical process. This method seemed to give her more confidence, she became more interested in her work and was improving at the end of seven months. Not able to count, she does hemstitching this way now, picking up the loose threads automatically with such precision that the finished work is absolutely correct.

With each new step, she would go through a period of discouragement, lose all faith in her ability, and sink back into her world of inferiority. Much psychotherapy was necessary to help her at this time.

After three years of intensive and persistent training, with the right kind of therapist who never gave up, Lillie accomplished what few other patients have matched in the great perfection of outstanding work in needlecraft, such as, a darning stitch in an openwork pattern on net, hemstitching on fine linen and other complicated embroidery stitches.

Comparing her work on her original material, the rug canvas with one-fourth inch holes, and her work now on French netting (used for bridal veils), which is the softest, most bodiless material known, with millimeter holes, one wonders what might have been accomplished if Lillie had received occupational therapy treatment at the age of ten instead of eighteen.

CASE 2

Anna, age 26

Admitted to Letchworth Village

	C.A.	*M.A.*	*I.Q.*
1-10-29	8.6	2.2	26
32	12	3	23
7-20-46	26.1	3.3	21

The case of Anna is presented because it is typical of the adjustment that a low grade defective can make when opportunities are given.

Anna is a feebleminded girl with unfavorable, hereditary background. Her mother died when giving birth to Anna and a twin brother. Both infants were placed in an orphanage where they remained until patient was adjudged mentally defective and committed to an institution on 11-23-23, and transferred to Letchworth Village 1-10-29 Her brother was placed in a foster home and was reported getring along nicely, although mentally retarded.

The patient at 8 years of age was reported not teachable and could say only a few words. She had temper tantrums and needed help in dressing and undressing. She was restless, sullen, unclean, and needed supervision at all times. The patient had not walked nor talked, had to be bathed and fed, soiled both day and night, was listless and very nervous, and had frequent screaming spells, which made it difficult to gain her attention.

Anna was 9 years of age when she was admitted to Letchworth Village, in 1929, and was put in a low-grade infirm cottage.

In 1933 a sense training class was organized for the younger patients in one of the infirm cottages. Anna's physician felt that she might profit from this training so he enrolled her in this class. She improved considerably and was transferred two years later to a low grade cottage in the children's group which made it possible to send Anna to occupational therapy. She was now 15 years of age.

At first the change into a new environment excited Anna to the extent that she would have frequent spells of crying or laughing and she would wander about the room without purpose. She was so full of energy that any organized activity was impossible, so play therapy was used. The games she liked best were jumping rope and playing ball.

At intervals she was given little pieces of cloth which she fringed, but this did not satisfy her. Seeing the other girls doing nice work, she soon expressed a desire to do likewise. It was amazing how quickly she learned, in contrast to the previous case with the same mentality, where it took 7 months to show some improvement. This might prove how beneficial habit and sense training is, with this type of patient.

Within one year's time Anna was able to learn oriental rug stitch and some embroidery stitches, like hemstitch and drawn work.

Anna has adapted herself well to the rou-

tine of her surroundings, but is quite incapable of coping with any unfamiliar situation. Even after ten years her nervous reaction is still quite abnormal. She is excitable and unstable at times and will get very upset and cry if she loses a needle, a stump of a pencil, or a scrap of paper. As soon as she gets it back, she will settle down and go to work again.

For a while most of her interest was centered around a small rag doll someone had made for her. She lost it and was unconsolable. Her therapist felt sorry for her and gave her an ordinary doll which she did not like at all. It was hard and she could not cuddle it. Finding a piece of unbleached muslin, she herself created a doll similar to the one she had lost. She was perfectly happy again. While working she will take the doll, talk to it and kiss it.

Anna can still speak only a few words such as, "I want red ball," "I need pattern," "Jump rope," "Wash hands," and will repeat parrot fashion, the last words of a sentence spoken to her. The words she speaks of her own initiative are accompanied by a great deal of gesticulation. She will copy some printed letters, but her drawings are unintelligible.

Anna is a very industrious, energetic worker, shows pride in her work and likes to be praised.

It is also interesting from the financial standpoint to know that from the sales of articles Anna has made, which are by-products of the treatment of occupational therapy, several hundred dollars were realized. Even though this does not make Anna self-supporting, occupational therapy has helped to keep her from becoming deteriorated and helpless.

CASE 3

Angelina, age 16

Admitted to Letchworth Village

	C.A.	*M.A.*	*I.Q.*
10-22-37—Stanford Binet	7.2	2.6	28
2-17-43—Arthur Point Scale	12.7	8.0	64
Goodenough Drawing 7-20-46		6.9	

Angelina is a good example of the therapeutic outcome of a continuous therapy treatment. Special abilities were discovered and through good supervision in a favorable psychological environment, her wasteful energy was led into productive channels.

Angelina's parents were born in Italy, and only the mother had some education. The father became insane and is still living in a state hospital. His diagnosis is psychosis with syphilis of the nervous system, meningo-vascular type. The patient was the last of eleven pregnancies. There are five brothers still living besides the patient and all are well.

At 7 years of age the patient was a great problem to her mother. She was an uncooperative girl, could not talk at all, had temper tantrums, and required constant care and supervision. She had a very wild temper and when angry would bang her head on hard objects. She was extremely destructive and took great delight in breaking things when having these tantrums. Angelina was excessively restless and irritable, wanted to have her own way, and had been quite badly spoiled at home. She was fond of other children but they did not like to have her around. She adored small babies and always wanted to pick them up and hug them. She was very strong and frequently hurt them in her desire to pet them.

Angelina was kept in the house most of the time as the family was afraid she would go off with strangers.

The public school did not take the patient but advised the mother to place the child in Letchworth Village, where she would receive education and discipline. Accordingly, Angelina was admitted to Letchworth Village in 1937.

Upon admission Angelina was a plump girl, rather large for her age, healthy in appearance, and somewhat attractive. She made no effort to talk or answer questions, although she sometimes cooed like an infant. At times she screamed and made sudden purposeless movements with head and arms.

The patient attended the sense training class, but made little progress. She showed little or no interest in the other girls and did not enter into games or other forms of play. She was untidy in her toilet habits both day and night. She was able to feed herself but could neither dress nor undress herself.

Angelina outgrew the sense training class, and, as she could not talk and was very over-

active, there were only two possibilities left, either send her to a low grade cottage or to occupational therapy.

Occupational therapy was chosen, and at the time of admission in September 1942, the patient expressed herself by meaningless grunts. She called everybody "Mama," which was the only word she could say. She was inclined to be overactive and ran about the classroom at will. She was affectionate, liked attention and sulked if it was not given to her.

It was amazing how quickly she learned to do things, and the enthusiasm she showed in doing them. She tended to be impulsive, but showed good perseverance. She was very much pleased with her successful performances and extravagantly pleased when praised. Her habit of wetting disappeared completely.

In November 1942 we arranged for her to have speech lessons twice a week. She could not pronounce C, H, I, J, S, Q, W, X, Z, distinctly. She was able to count from 1 to 10 without any assistance, but beyond that she needed a little coaching. The speech teacher had to give her up for lack of interest in this pursuit.

The performance of Angelina's craft work became so outstanding that we felt her intelligence must be above an I. Q. of 28. In 1943 at the age of 12 years, we had her retested by the psychologist. Because of her speech limitations the Stanford Binet was not administered. On the Arthur Point Scale she received an M.A. of 8 and an I.Q. of 64. Angelina obtained an M.A. of 14 years on the Kohs Blocks. The great discrepancies between her performance on this test, and her general performance obtaining an M.A. of from 6 to 8 years, the examiner felt the test was a representative measure of Angelina's performance ability with concrete material and accounts for the special abilities which she has exhibited in her craft work from the very beginning.

Angelina is now a girl of 16, good-looking, neat, and physically well developed. She is an expert in weaving and is very industrious. She is able to print her name, and also a few simple words, as "cat," "dog," "Mama," and "baby." Her speech is gradually improving. She makes friends easily and shows great pride in her accomplishments.

Angelina's progress gives real proof of the importance of occupational therapy with this type of patient. Without this treatment, the patient's special abilities probably would never have been discovered and the behavior problems she presented might never have been checked. With her explosive temperament and inability to talk, she could easily have become a resident in an infirm cottage becoming more unmanageable as the years passed.

CASE 4

Theresa, age 16

	C.A.	*M.A.*	*I.Q.*
Admitted to Letchworth Village 11-2-34	5	3	55
Admitted to Occupational Therapy—1942	12	3.9	42
1945—Stanford Binet	15	6	39
" —Arthur Point Scale	15	8.3	54

To prove my point that in many instances the I.Q. of a child can be raised and that disciplinary problems often disappear while work habits are being cultivated, I present this case of Theresa.

Thersa is a white girl, of Hebrew faith, born out of wedlock. We have no information on the father. Her mother was a dull person with a serious speech defect whose I.Q. was 64. The mother became pregnant while in the 6B grade at school. After she had the child her parents took her to Canada, and she has not been heard from since that time.

Shortly after birth, Theresa was admitted to a Hebrew Children's Hospital, where she remained until she was two years old, and then placed in a foster home. At the age of two years she could walk, but could not talk, and to this day has a slight speech defect.

While in the foster home it was detected that the patient was unable to play normally with other children and that she was mentally defective. As she was without relatives to assume care of her, she was admitted in 1934, at the age of 5 years to Letchworth Village. Her M.A. at the time of admission was 3 years and her I.Q. 55.

When Theresa was 9 years old she was admitted to the first grade of our academic

school. The report at that time from her teacher was, "Incapable of doing good work, because of inattention. Cannot keep her mind on one thing, talkative and troublemaker. Seems to day dream all the time. Slow to react to direction."

At the age of 10 the patient's report was somewhat better, "Theresa does good work but her behavior is bad, and not at all dependable because of her nervousness."

She became more and more of a behavior problem in the classroom so that the head teacher finally asked to have her taken out of academic school. She was too young to be put in the hospital industries and was not the right material for it, on account of being a behavior problem. Her physician thought the treatment in occupational therapy might better her condition, so was admitted in 1942, at 13 years of age, with an M.A. of 39 and an I.Q. of 42.

Theresa resented somehow being taken out of the academic classes. In the new environment she was quiet at first, did not mix in with the other girls, would just sit and watch them work. Not even at recess would she join the girls in their fun. It was a full year before she adjusted to the classroom activities and the children. During this time she would never express herself to the therapist when spoken to. She would not reply, just nod her head, but through another patient, she would send word that she did not care to do a certain thing. She would disturb the other girls near her, often, so had to be seated by herself.

The therapist tried to interest Theresa in various crafts but did not get any response. About two weeks after she was admitted to occupational therapy, she did try needlework, but when things seemed difficult she was inclined to be petulant. It took some time for her to learn because she did not have enough patience to go through the somewhat tiresome learning processes. After she knew how to do a thing, she wanted a change and jumped from one craft to another.

The explanation of a behavior problem involves an analysis both of the individual who manifests the behavior and the social order that declares the behavior unacceptable. These two aspects of a behavior problem cannot be divorced from each other any more readily than the factor of heredity and environment can be disentangled for the explanation of "normal" behavior.

The teacher's complaint in our case was: inattention, acting smart, failure to study, impertinent, willfully disobedient, lack of interest in work, meddlesome, stubborn in group, sulky, and temper outburst.

The therapist regarded the conduct of the child symptomatic and significant of the maladjustment. The problem with Theresa was her shyness, over sensitiveness, fearfulness and suspiciousness. After the therapist took those symptoms as the underlining cause for Theresa's behavior, and helped her to overcome them, it was surprising to see how quickly she responded to treatment.

She became an ambitious pupil, enjoying her school work and performing it well. She is fascinated with knitting designs, involving cables and lacy patterns. Even though she cannot read, she learns quickly by memorizing them. She particularly likes to make baby things, preferably pink.

Due to the performance of her work, which her therapist felt was much higher than that of a mentality of 3 years, he had her retested. On the Stanford Binet she received an M.A. of 6, and on the Arthur Point Scale an M.A. of 8.3.

A real test, of course, would be to send Theresa back to academic studies and see if she could do better there, too.

RESUME

In summarizing this paper, the following points are significant:

1. Medically and economically the imbecile patient is one of the major administrative problems in State Schools.

2. In order to keep this type of patients from deteriorating and becoming a nursing problem, a well rounded training program is necessary.

3. The occupational therapy activities are flexible and varied and can be adjusted to the needs of many in the imbecile group, by substituting healthful activity for destructiveness and untidiness.

4. Activities must be suited to the patient's needs, and the methods of instruction used

must be of an individual nature.

5. After many years of experience, we are thoroughly convinced that occupational therapy has definite values to contribute to all phases of this problem, if its purpose is to train the patient for better habits; to ease emotional stress; to control his abnormal responses and give a constructive outlet for his unused energy.

6. It is impossible to underestimate the importance for the success of this program to have adequately trained personnel who have an appreciation of the rational and psychological basis of the treatment.

7. A close working relationship with the physician, psychologist, and the cottage personnel is essential.

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Escape From Nonsense

By HOLLAND HUDSON

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In the evolution of an adult state of mind, relinquishment of naive and childish concepts is as important as the acquisition of new information. The current scene supplies fairly obvious illustrations of the ability of some children to surpass many adults in fluent command of information, the while we are all plagued, at every turn, by persons who, while chronologically adult, retain the emotional patterns and the folklore of childhood. Few adults actually escape enough of the nonsense of their tender years unless they give habitual examination to the actual premises and processes of their opinions and decisions. Rationalization, in apparently logical terms, of impulses which have their roots in the superstitions of childhood is one of the most popular forms of self-deception.

Professions, because they are made up of human beings, are subject to a similar evolution and a similar lag in maturity. Professional practices, in conscientious hands, find improvement from the results of scientific inquiry. Professional workers employ the words "science" and "scientific" with a religious zeal, wishing to emphasize the superiority of their methods to the unblessed products of folklore. The desire to escape from the chains of childish nonsense into the empyrean of adult information, to substitute research for fantasy and logic for fears, is an admirable formula never completely realized in the present state of mankind. A time lag colors today's procedures still with yesterday's nonsense. Almost a generation is required to catch up with major premises.

As we review the evolution of medical practice in the United States, objective illustration of these generalities is abundantly supplied. In its beginning, American medicine labored with the concept of "humors," with a *materia medica* which shared the human tendency to fill each vacuum in our information with fantasy. Its therapy ran chiefly to bleeding; its pharmacopeia to old wives' simples, most of which modern research finds to be devoid of physiological effect. What should be noted is that, in the course of some generations, some absurd concepts were relinquished; therapies were improved; the pharmacopeia was revised.

Other illustrations are supplied by the evolution of the modern hospital, dispensary, and clinic and the growth of public health services. Among many important facets of these items in preventive medicine, the utilization of supplementary skills was one of the most basic contributions to the health of mankind. In these settings, the physician called upon skilled colleagues for services in which their experience or preparation exceeded his own—for example —surgery, obscure differential diagnosis, or special treatment. He began the delegation to trained nurses of the application of treatment and daily care of his patients and, eventually,

of a part of the instruction of the patient and his family. The evolution of an improving hospital service is also the evolution of the further utilization of supplementary trained skills, such as those of the pathologist and roentgenologist, the laboratory and X-ray technicians, the dietician, the physiotherapist and the occupational therapist. Each of these supplementations provoked that bitter opposition which change and innovation inevitably encounter, but each has survived that natural phenomenon.

One of the daily problems of our hospitals and other health services is the nonsense commonly cherished by most adults about the purposes and practices of a hospital and its staff. To millions of our people, the hospital is still fundamentally a place of suffering and death instead of a means for the extension of life. The images of fear engendered by the history of someone hospitalized too late for a satisfactory result persist, and the many stories of recovery are forgotten. This brand of nonsense is a considerable factor in niggardly appropriations for the operation of public hospitals and sanatoria. Why spend so much, argues the appropriating group, on the dying? The danger of such nonsense is that underbudgeting means understaffing, and understaffing means a poorer medical result. The progeny of such nonsense is avoidable invalidism and deaths in communities which must spend more on relief and welfare service because they will not finance adequate medical care.

Man's attempts to control tuberculosis are peculiarly rich in illustration of man's struggle to escape from nonsense. All too often, pathetic nonsense has increased the hazard of the patient infected with tuberculosis and has defeated the intentions of those who hoped to aid his recovery. Much of the progress in the diagnosis and treatment of the disease has consisted in escape from accrued nonsense of the past. The discovery of Robert Koch that the etiology of tuberculosis is the tubercle bacillus was an emancipation from much nonsense about other alleged causes, nonsense spawned by that persistent human tendency to fill the vacuum of ignorance with fantasy. The American popularization of rest treatment by Trudeau delivered patients from horseback riding, sea voyages, and other frequently fatal nonsense which once had a firm place in the prevailing therapy.

In terms of the national scene, the treatment of pulmonary tuberculosis has never wholly divorced itself from yesterday's nonsense. A lunatic fringe of weird diets, costly nostrums, and alleged specifics persists around the sensible core of rest therapy. Nonsense triumphs with some persons whose faith in the resistances and recuperative powers of the human body is insufficient to accept this as the most effective treatment thus far determined. Nonsense at the newspaper city desk inflates each new experimental preparation or bacteriostatic compound into a wonder drug, a "cure." The nonsense of our elders located hundreds of sanatoria in remote and inaccessible spots in search of elevation, and gave credence to other now exploded factors whose therapeutic effectiveness in tuberculosis was, and is, negligible. It designed structures which afford neither comfort, safety, economy, nor working efficiency in operation and administration. To escape from this nonsense to modern, accessible hospitals is a major problem of future tuberculosis control planning.

Is it any wonder, then, that the application of occupational therapy in the treatment of tuberculosis has shared such misadventure? Or that a considerable adjustment is necessary before it can reach a general recognition and application in this field comparable to that which it has achieved in some others?

The nonsense which obstructs such a consummation is, as usual, not the fault of any single individual or group. Some physicians have learned, usually by trial and error, how to use occupational therapy as an effective supplement in the treatment of selected patients. More have evaluated it, somewhat contemptuously, on a basis not far removed from folklore, or as a result of some unhappy experience with one of its least representative practitioners. More than a few of the instructors in respiratory diseases in our medical schools have had no experience with occupational therapy. A number of the graduate therapists who are attempting to serve tuberculous patients have had less specific preparation for this than for any other type of medical service. Some know so little about the disease for which the patients are treated that they resent the occasional reduction of a patient's exercise, prescribed by the physician and undertaken and ordered for clinical reasons, as a personal affront to patient and

therapist. The net result is often an array of diversions and busy work which, while making some valuable contribution to general patient morale, seldom achieves its optimum role in effective treatment of the individual patient. The number of therapists employed in hospitals and sanatoria is today on the down grade despite occasionally generous salaries. Recognition and effective results are often as necessary to a professional worker as a pay check.

How may the profession of occupational therapy escape this particular segment of nonsense? This inquiry might be directed to the Council of the American Trudeau Society. Thus far, however, the committees of the A.O.T.A. have sought to find what has been done instead of what needs to be done in the training of the therapist who is to serve the tuberculous. The Army manual made a step in this direction but its circulation was limited and it has received little follow-through from occupational therapists. This rut seems likely to prolong the literal transfer of therapy projects designed for orthopedic and mental patients to patients whom they serve less well. While it continues, chest specialists will continue to wonder what to do with an occupational therapy service, if they have one, and why they should inaugurate a service which has not worked out techniques of substantial therapeutic value in this disease.

Let's be more specific. In the hospitalization of pulmonary tuberculosis, the core of the treatment is a revolutionary change in the patient's way of life, for a long interval. From violent activity he must change abruptly to virtually complete immobility in which he must remain for months on end. This is not easy for anyone to take and it is hardest of all for restless young males to accept. When will occupational therapists be equipped with a repertory of projects for bedfast patients, making a minimum of physical demands and offering major interest to male patients? When will they be prepared to work congenially with others, not only the physician and the nurse, but the social worker and the counselor as well?

A few occupational therapists have found out how to do some of these things which are needed in practical service for the tuberculous. It would be fortunate if they were also writers, so that they might inform others. In that case, the occupational therapist seeking to serve the tuberculous would not have to find her escape from nonsense the hard way. During the last few years, a number of training schools have substantially improved the selection of their affiliations for training-in-service for the tuberculous. This is a good beginning of escape from nonsense in professional preparation.

Can we say as much for the fashion of making the tuberculosis affiliation an elective in some schools? Unfortunately, this is often coupled with the assumption that affiliations in other medical service are wholly free from risks of infection—an assumption as yet unwarranted. In a group of professional patients under treatment for tuberculosis—doctors, nurses, medical students and nursing students—come far more frequently from general hospitals than from sanatorium duty. Some general hospitals have made a chest X-ray routine procedure for all new admissions, but far more are still exposing their staff and student workers to undiagnosed diseases. The fashion of which I complain has the advantage of screening out the immature from this field, but the superstition thus encouraged tends to linger far into adult life.

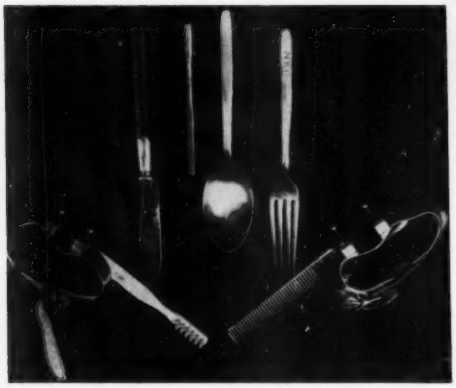
The whole field of therapeutics is like a running stream; in motion it sparkles, cleanses its content, brings life to what it touches. Today, yesterday's waters have been replaced by new material. To stand still is to stagnate, to lose vitality and values. Is it nonsense to suggest that if occupational therapy is to achieve optimum value in any field of medical practice, its practitioners and its professional groups must look forward instead of backward?

Sometimes one escapes from nonsense by growing up.

An Occupational Therapy Aid for Paraplegics

Edward W. Lowman, Comdr. (MC) USN and Fred Liphum, C.Ph.M., USN

In the rehabilitation of patients with paralysis or marked weaknesses of the hands, there is often a demand placed upon the ingenuity of the occupational therapist to provide devices for augmenting the patient's residual muscle capacity to a materially productive level. Particularly has it been a problem to provide suitable occupational therapy pursuits for certain traumatic spinal cord injury cases wherein the



lesions have occurred high, effecting not only paralysis of the lower extremities but also weakness in varying degrees of the upper extremities. Fortunately, in this latter group, those who survive to be rehabilitated usually have retention of power in shoulders with graduated loss peripherally in the upper extremities, with greatest weakness in the fingers and hands.

In these cases with marked weakness or paralysis in the fingers and hands, a device has been used in one Naval Hospital with considerable success in the improvement of the patient's functional capacities and thus in their self-sufficiency. It consists of a light metal band fitted across the palm of the hand and strapped dorsally (fig. 1); on the palmar surface are two slots with turn-screws. Into these slots

may be inserted a toothbrush, a comb, eating utensils, and various occupational therapy tools. With this aid, the patient is not only able to provide himself with much of his personal care, but occupationally may engage in a variety of pursuits (fig. 2) including hooking rugs, simple leather projects, typing, etc., (fig. 3), all of which otherwise would be impossible challenges.

In cases where weakness impairs function at the wrist or in the forearm, a brace may be extended from the hand device to fix the wrist or forearm in a position conducive to the most efficient function of the hand device.

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Rehabilitation—What is it?

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The National Council on Rehabilitation defines rehabilitation as: "The restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable."

In Webster's Dictionary we find that "to rehabilitate is to restore to a former capacity; to fit to make one's livelihood again."

Dr. A. R. Shands, Jr., Medical Director of the A. I. duPont Institute, Wilmington, Delaware, has said: [1]"What place does rehabilitation occupy in medical care? It has been stated that there are three large divisions of the practice of medicine, namely: Prevention; Diagnosis and Treatment; Convalescence and Rehabilitation. The first of these, Prevention, is the primary responsibility of the Public Health Agencies. The second, Diagnosis and Treatment, is carried out by the medical profession and hospitals. The third, Convalescence and Rehabilitation has generally been the neglected child of this medical family and whether it has been satisfactorily effected without the aid of an established program has been largely a matter of chance. The orthopedic surgeons with the predominance of long-term cases in their practices have always recognized the importance of a comprehensive and well rounded program of convalescence and rehabilitation, and in a few communities have had limited programs in operation. However, the average busy physician or surgeon, when the actual medical treatment has been completed, usually feels his job is done. Perhaps in the old days of the time-honored family physician, the full program of medical care and rehabilitation was carried on by the one physician but in these days such is seldom effected by the doctor. However, the actual medical care can only be considered the first step in the restoration of the patient to optimal health. A rehabilitation service should now take over and complete the job."

There are ten important factors requisite to a sound rehabilitation program. They are not ten separate steps but they are the necessary components of the service. The whole must click as a "team" and there is no place for individual stars excepting insofar as they help in the teamwork required to make the whole function smoothly.

These ten factors as we see them are:

1. Mental Hygiene or Psychological Preparation
2. Social Service.
3. Morale maintenance and building up
4. Physical Therapy
5. Occupational Therapy
6. Recreation and Entertainment
7. Education
8. Vocational Counsel
9. Physical and Vocational Rehabilitation
10. THE WILL TO GET WELL.

Any physical injury carries with it a more or less severe mental injury depending on the make-up of the individual. Only too frequently this is not realized chiefly because we are apt to be so absorbed with the immediate anatomical and physiological problem that we may forget the *whole* human being with whom after all we are dealing. Maybe we should say with whom we are *primarily* dealing as the somato-psychic potentialities may present as difficult a problem as the purely physical ones. The treatment of the condition not infrequently overshadows the treatment of the individual who has the trouble. This should be avoided.

At the first moment consistent with good medicine the Ten Factor Team should swing into action with of course the physician in charge as Quarterback. He should know all the "plays" and be able to call the signals which will be for the best interests of the patient.

We know that mental attitude can markedly influence the progress of a patient and he must not be allowed to decondition mentally any

more than it is permissible physically. It is not good medicine to let either condition develop when both can be avoided.

Social Service is to a large extent responsible for this phase in helping the patient to adjust himself to the sudden change in his daily life. For example, he may need reassuring that his family will be taken care of; his job held for him; finances taken care of; in fact any matters tending to worry him will be attended to so that he can devote his whole energy to the process of getting well.

His morale must be maintained or built up by keeping him occupied in order not to have the time to brood and become bored. Distract his attention from himself by recreation and entertainment between periods of therapy.

A word here about recreation may not be amiss so as to clarify what is meant by "recreation." It is *not* the function of occupational therapy to direct or provide purely recreational activity.

The Recreation Worker will frequently employ many of the media used in occupational therapy BUT for a different purpose. Participation in recreation is voluntary whereas in occupational therapy it is on a prescription basis as a part of the medical treatment. It should be supervised and planned by a professional recreation worker trained in this field—not just a haphazard procedure.

In prolonged cases with the prospect of a lengthy hospital stay there is the opportunity for completing or supplementing education. The opportunity for study may be welcomed by a certain number and should be provided for in the program. This requires a fairly comprehensive patient-library of appropriate textbooks as well as the customary supply of reading matter with which the hospital librarian is familiar in order to be ready to cater to the various tastes of the patients.

The Vocational Counsellor is a most important member of the team. Training and experience are essential as a thorough understanding of the individual's problems and capabilities is necessary in order to guide him successfully into a new field in which he is to become economically independent. The old employment is no longer open to him because of the handicap sustained and it is the responsibility of the counsellor to guide wisely and well as the patient's entire future may depend on the decision.

Rehabilitation is, as stated at the beginning, the restoration of the individual to economic usefulness. This may be relatively simple or extremely difficult depending on the severity of the injury and the individual himself as to how soon he is ready to resume work. A traumatic neurosis may develop after a relatively slight physical injury which means that the mental damage is out of proportion to the physical damage thus impeding full recovery. On the other hand, a patient with a more serious physical injury may be ready to return to work sooner than the previously mentioned one as his mental damage has been relatively slight and all his energy has gone into helping himself towards speedy recovery.

This brings into prominence the tenth factor which is The Will to Get Well. Once the immediate, acute phase has been successfully passed some 85% of the work in recovery depends on the efforts of the patient. If he is not interested in getting well or develops the complication known as "Compensitis" the best organized rehabilitation program in the world will, in his case, fail or be rendered ineffective. One objective of a well-drilled team is of course to prevent this from happening. It is not easy but when this potential complication is kept in mind *from the beginning* preventive measures can frequently be instituted by good team-work and no broken-field running attempts by any one self-appointed star player. This *must* include the quarterback!

In the 9th factor we note Physical *and* Vocational Rehabilitation. To be sure all rehabilitation after injury is physical (we are not going deeply into the mental phase at present) but what is meant is that straight physical rehabilitation is the return of the individual to the same job held before injury, and any well organized hospital with a smoothly functioning program will be able to do this. When however the patient because of a handicap resulting from the injury will not be able to return to his former occupation but will have to be trained in a new occupation, then Vocational Rehabilitation has to be instituted. This generally requires special facilities which will seldom be found in a civilian hospital. It is a much longer and more difficult procedure but the *pre-*

vocational training *can* be started.

The liaison with the local Vocational Rehabilitation Agency is here of the utmost importance as through it facilities are available for training the individual who otherwise might present a problem in rehabilitation beyond the physical capability of the hospital. Every rehabilitation program must provide this liaison.

It is well to know that the Office of Vocational Rehabilitation, Federal Security Agency, has a main state office in each one of the 48 states as well as in the District of Columbia, Hawaii and Puerto Rico with some 286 Branch Officers in the states and Puerto Rico. The services of these agencies are open to any person whose disability constitutes a handicap to employment, provided that:

1. He or she is of working age.
2. Has a substantial job handicap because of physical or mental disability.
3. Has a reasonably good chance of becoming employable and holding a more suitable job through the rehabilitation service.

Physical therapy ties in closely with occupational therapy and the chiefs of the departments should frequently confer about the patients especially in the earlier stages of convalescence. Preventive physical therapy should start as soon as possible on the ward while the patient is still in bed to avoid deconditioning and its attendant complications such as contractures and atrophy of disuse.

Later on the patient when ambulatory or in a wheel chair may require physical therapy before going to the occupational therapy department and here is where the liaison between the two therapies is so important. The idea that occupational therapy takes over where physical therapy leaves off is not tenable nor is it good thinking because in many instances they supplement each other for the best interests of the patient.

In rehabilitation the one main fact to be kept continually in mind is that the whole team has but one objective—namely, the restoration of the patient to as near normal as possible by using its combined skill to *his* best interests.

Occupational therapy is aimed to accomplish what the physician desires in such a way that the patient will cooperate to the fullest. By diverting the patient's mind from his infirmity through absorption in accomplishing the task assigned many a restoration of function can be obtained which by more prosaic or less interesting procedures would fail to stimulate the patient in his efforts.

Some 23 years ago, Dr. B. W. Carr, then in the Veterans Bureau, said, [2]"The patient with stiffened fingers and wrists will exercise these members by weaving, modeling clay and even grasping a hammer or saw because of the interest in the work, when he would do but little in the way of loosening the joints by simply bending and straightening the fingers and hands as exercise. . . . It makes convalescence more bearable . . . (and) the patient pleasantly occupied makes the more rapid recovery."

Well—this is the end of our little ramble and it is hoped that it may stimulate some thought on the subject.

The whole process of converting a presently unemployable into an employable, self-respecting, economically independent asset to society is such a completely worthwhile obligation that we sometimes wonder why there are so many difficulties encountered which tend to slow down the establishment of more facilities to accomplish what will convert a possible liability into a positive asset.

References:

[1]Shands, A. R., Jr., M.D., Nebraska State Medical Journal, Dec., 1946, p. 480.

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Prevocational Activities for the Physically Handicapped

By Caroline Goss Thompson, O. T. R.

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The position of the young handicapped person who competes with able-bodied workers for a job is a matter of concern not only to his family, but to the community in which he lives. It is to the solution of this problem that I would like to direct your thought, since occupational therapists are fitted both in background and in sympathies to help in his dilemma. Once they are aware of the prevalence of the problem, they need only know how to make their contribution most effective by implementing it with half a dozen known techniques.

Occupations vary, and it is never practicable to offer in an occupational therapy workshop, vocational training, or even a wide range of work experience. It is not necessary. Experience should be given in work that is available in the community, In every town, clerical workers are needed in the offices. Where such jobs fall under Civil Service, they offer added security by promising continuing employment to the crippled girl who has passed her examination. Clerical work fits the restriction of activity imposed on the cardiac and ex-tuberculous patient, as well as those with an orthopedic disability. It does require at least a high school education as otherwise competition with the able-bodied is apt to prove too steep.

In many areas, a knowledge of power machine sewing will successfully gear the handicapped worker to jobs in factories and hospitals where the possession of two strong legs is not after all a vital factor, — where even two frail ones in braces may do. Clara, a polio with double-bar long leg braces, could operate any power machine run by pressure on a knee lever. However most manufacturers possessing this out-moded machine use it so seldom that her requirement of special equipment would definitely limit her employability. As she was quick with her hands, it was suggested that she plan for inspection work. Clara, however, liked to sew and had determination, so while the therapist sat on the floor in front of her machine, ready to lift the treadle manually and so stop the machine if her patient was unable to cope with it, Clara by trial and error devised a way of shifting the weight of her braces from the hips that eventually gave her complete control in operating the machine.

For men and girls alike, assembly and inspection work requires essentially quick fingers and familiarity with reading the more usual micrometers. This is seated work and does not take a college education. It does mean self-respect and independence to many crippled workers. Again the use of electrically operated tools — lathe and drill-press — serves as an introduction to industrial processes. The patient with arrested tuberculosis, the man with a bilateral amputation of the legs, quickly discovers the affinity between his work tolerance or hardening program and a job which may support his family.

None of these activities requires a special training of the therapist, who has had experience with electrically operated machines for sewing and woodwork, who has typing texts available from her public library, and can acquire a sampling of the micrometers in use locally. She needs instead a special outlook, and an attention to commonly forgotten needs in her patients.

They do require machines: power machines for sewing if they can be had; at least one for the final work-up. A common substitute in the earlier stages could be the old-fashioned model converted with a motor. In woodworking tools, to approximate those used with metal in the manufacturing plants the minimum would

be an electric saw and lathe, available in many out-patient workshops. Often an office typewriter can be commandeered for the use of the more careful patients. Switchboard practice, mimeograph, and dictaphone transcribing would be found in certain institutions, while those without could manage on the minimum of equipment suggested above.

Next one needs materials to work on and preferably orders, so your patients can begin producing on a simple level in the first few days. The arrangement should be elastic as to delivery date. Speed will be variable. Standards of work should not.

Addressing envelopes will give experience to the typing group. This can be done for charitable organizations mailing publicity or annual appeals. They will supply the paper. Street signs in need of repainting may be furnished by the city and give continuous practice to the painting crews. Hospital sewing, often simple in construction and very evidently needed, gives the sewing room satisfying work experience of varying degrees of difficulty, and as well a means of building speed of performance to an industrial level. The cost of materials on any of these projects is paid by the consumer. The workers benefit immeasurably through the practice provided, so that in time they are able with few exceptions to achieve their goal — employment in industry.

Jim was one of the exceptions. His was one of those unusual cases in which a tuberculous patient progresses more satisfactorily at home. His stay at the sanatorium was during an era when no organized activity was provided, and his restlessness there contributed so little to his health that the doctors decided to return him to his home. The problem was one of how to increase strength gradually while promoting mental rest. Jim's former job as an electrician was out of the question for one with moderately advanced disease, and the probability of a permanent limitation of activity. It was thought better for him to plan to set up a small business, requiring little capital, in his own home. A battery of tests, correlated with his background, gave the clue, and a correspondence course on radio, provided by the State Vocational Rehabilitation Service, started him happily on his way. Two or three defunct radios furnished laboratory material, and daily for the two hours of activity he was allowed by his doctor, the occupational therapist explained puzzling words in the lesson, while Jim, the electrician, explained the diagrams. Jim today is on his own in a useful service industry that brings in a steady small supply of cash, and more important allows him to keep his own hours as prescribed and thus maintain his health.

How many patients need this type of service — regular working hours enabling them to build up gradually to a full day, the establishment of work habits and work tolerance, the concrete evidence that in spite of a handicap they are able to contribute to their families and to society, and perhaps for the first time the experience of usefulness. The numbers are greater than we have admitted. The concern of the patient is there.

Even foreseeing such a goal for your patients, it would be unwise to attempt this program without having available at the start of treatment, interest and aptitude testing such as is done by many of the State Employment Offices. This furnishes an objective evaluation of talents and capacities which will help establish the goal.

The physical evaluation will be a cooperative venture for the physician, occupational therapist and patient. Once the vocational goal has been outlined by a competent psychologist, through interest and aptitude testing, we are in a position to confirm or qualify the findings, through a practical tryout with actual processes and materials. This would approximate rather than duplicate working conditions. The patient with a severe kyphosis who is unable to supply sufficient pressure to hold lathe tools against revolving wood should not be encouraged to consider a welding job.

A second matter to consider at the start is whether there might be funds available for "scholarships." If a small monthly sum can be given the patient to cover carfare, lunch money, and an occasional movie, participation in the program will mean at once an added independence for the patient, who has often had to ask for every cent he used. It gives him a foretaste of money earned.

In scheduling these patients, there are some special considerations, but none that cannot be worked out by timing if special space is not

available. Particularly with these patients, the experience of belonging to a group has an almost disproportionate value, so it is well to set up treatment with this need in mind. Even the 50-year-old arthritic toolmaker can offer a commonsense viewpoint and a lot of support to younger members of the group that more than makes up for his occasional political bitterness. On the other hand it is well to separate them from patients coming for specific exercise. One is subsidized, while the other may pay for treatment. The aim of treatment too is so diverse that the method by which a job is done must vary, and this to patients is often inexplicable. Then too the more rapid return to work of the exercise patient is not missed by the prevocational patient, who knows it may take months for him to achieve sufficient hardening to compete in industry.

It will not always take so long. Harriet, who wrote in for help and information about placement, is a case in point. The illness of her father who was the family wage-earner had suddenly forced this responsibility on her. She was forty years of age, and had never worked. A severe orthopedic condition had deformed her in childhood, and made travel difficult. On applying recently for work at a number of plants, she had invariably been turned down. An orthopedic examination revealed that the crutches she had used for twenty years were no longer needed. They certainly increased her appearance of helplessness, and the doctor advised her to walk with canes. Plans were made for her to commute daily to the workshop from her home town by bus. This gave her experience in getting about independently in all types of weather. The therapists worked on eliminating mannerisms, and building self-confidence while giving her practice for an increasing number of hours each day on power machine sewing, and on reading micrometers. At the end of the month, she returned to the Employment Office and herself secured an inspection job which has solved her economic problem.

As each patient reaches this point, when his doctor feels he is ready for full-time work, he returns to the Employment Office as Harriet did, for a placement interview. Here the test results are on file, and a detailed report from the therapist at this time fills in the background with information on personality traits and physical limitations, gleaned from her close acquaintance and observation of the patient. A realistic statement helps each patient to obtain lasting employment in work that fits his individual abilities.

I am not convinced that this is work exclusively for the out-patient services. Many of the patients first treated at this stage might profitably have done the groundwork during previous months of hospitalization. Facilities can be found for early prevocational activity. Work with radio kits, shorthand manuals, fly-tying (in those areas where there are factories) can be begun in bed. Let your 17-year-old burn case read up on chicken-farming. The chickens will not be frightened at his appearance. Get a college extension course in sociology for that intelligent polio patient who plans to be a court reporter — a job that means short intense hours of highly paid work, that fits in with his obvious ability and interest in clerical performance, and his concern with social problems. For the girl with the recent shoulder amputation, certainly teach her how she can tie her shoe, but along with that encourage her to continue in her office job since she tests high in clerical ability. There is only one item of retraining. You can help her to start typing with one hand, and thus compensate directly for her lost typing speed of ninety words a minute.

These things provide strong motivation for any patient with a disfigurement or disability severe enough so it will interfere with his economic adjustment. The contribution of the clinical psychologist and the social worker are essential here. With their aid, the occupational therapist can send her patient home with several possibilities for future vocations in mind, and the address of at least one local agency qualified to help attain them.

The Future of Occupational Therapy in the Army

Paper Delivered at the Annual Convention of the A.O.T.A., 1946

By WILMA L. WEST, O.T.R.

Referring to previous remarks concerning the decision that occupational therapists would not be given military status, personnel entering Army hospitals in World War II were given Civil Service appointments. At that time occupational therapy positions were still placed under the division of Trades and Industries and were based on existing standards of the Civil Service Commission. Applications for occupational therapy positions were reviewed purely from the standpoint of a knowledge of arts and crafts, and existing positions in other government agencies were used as a standard. Educational requirements were *not* a consideration and professional registration was not recognized. Even later, when occupational therapy was transferred to the Medical Division of the Federal Civil Service Commission, personnel was still classified in the SP (sub-professional) Series. Still no standards had been established by the Commission for proper selection of professional qualifications.

Fortunately, the War Department was successful in establishing requirements for personnel appointed in Army hospitals as graduation from an approved school of occupational therapy or registration by the American Occupational Therapy Association. As a safeguard against local appointment of unequalified personnel, it was also required that appointments made from sources other than those referred by the Surgeon General's Office receive concurrence from that office. In this way it was assured that only personnel meeting professional requirements would be appointed. (This is the only instance where lack of personnel at the beginning of the war was a distinct advantage.) The War Department did not have occupational therapy personnel as Civil Service employees with years of service, and consequent varying degrees of training as did other agencies. It was, therefore, not so difficult later when there were more trained occupational therapists doing professional work in Army hospitals to have positions reclassified, under the authority granted the Secretary of War.

Occupational therapy was organized in World War II under a plan for reconditioning of convalescent soldiers. The mission as stated in official Army publication was: ". . . . to accelerate the return to military duty of convalescent patients in the highest state of physical and mental efficiency consistent with their capacities and the type of duty to which they are being returned. Or, if the soldier is disqualified for further military service, the Reconditioning Program must provide for his return to civilian life in the highest possible degree of physical fitness, well oriented in the responsibilities of citizenship and prepared to adjust successfully to social and vocational pursuits. The mission is accomplished by a coordinate program of Educational Reconditioning, Physical Reconditioning, and Occupational Therapy." In order to assure an equitable distribution of available occupational therapists, a personnel guide was established for the assignment of occupational therapists on the basis of one for each 250 authorized beds. Additional therapists were authorized for special programs such as amputee, paraplegic, poliomyelitis, tuberculosis, etc.

So important was the morale factor in Army hospitals that it was considered of utmost value for occupational therapy to carry on an extensive diversional program. It was possible to effect such a program under occupational therapy supervision by the use of members of the Arts and Skills Corps recruited by the Red Cross and assigned to occupational therapy departments. This was possible in hospitals which were located in or near metropolitan areas. In the more isolated areas, where such personnel was not available, enlisted WACs were assigned to assist in the diversional program. In this way, trained personnel was freed for functional and administrative work. In order that the program could be extended

as far as possible with limited professional personnel, civilians were also employed as tool clerks, secretaries, craft instructors, etc.

Soon after V-J Day, when the necessity for an elaborate program of reconditioning for return to duty had diminished, and emphasis was being placed on longer term medical care, plans were drawn up in the Surgeon General's Office for the establishment of a Physical Medicine Consultants Division to replace the war-conceived Reconditioning Consultants Division. This change was effected on 4 April 1946. Plans are now under way for the establishment of Physical Medicine as a major service, comprising Physical Therapy, Occupational Therapy, and Physical Reconditioning in all general and larger station hospitals.

In retrospect of the past and summary of the outlook for the future, then let us briefly consider certain signal facts. Although it is not generally remembered, consideration was given the question of military status for nurses, dietitians, occupational and physical therapists immediately following World War I. The latter three groups did not wish to accept such status for two reasons: (1) they earned more money as civilians, minus any benefits, and (2) they felt they had more personal freedom. They therefore remained in a civilian status and were paid from a special fund established at the hospital level under the Post Commander. Just as for other civilian employees, at the end of each fiscal year, it was frequently questionable whether sufficient funds would be provided for such salaries during the coming year. Occupational therapy personnel at Walter Reed, for example, was reduced from over 100 to 17 in the space of a few years, and that number remained until the Economy Act of 1933 eliminated not only the training courses, but all except two occupational therapists. Similar instances of reduction, due to lack of funds, drastically curtailed occupational therapy programs and personnel in all permanent Army hospitals. This condition persisted until a year and a half after the start of World War II, when, as has been previously stated, we consequently were handicapped at the outset by the shortage of personnel necessary to an adequate program,

Tomorrow, 14 August, 1946, will mark the first anniversary of the end of the second great world conflict. It is sincerely hoped that it will not also mark an error in the course of action which our profession will take from this point forward. Already the signs of history repeating itself are in view. In the 364 days that have passed since the end of the war, 619 Army occupational therapists have been separated from the service. This is an appalling average of nearly two per day. It is true that the overwhelmingly majority of these reductions has been occasioned by the deactivation of large numbers of hospitals. However, an increasingly large number of them from this point forward will be due to Bureau of the Budget Determinations to cut national expenses by reduction in force of civilian employees.

It seems only too evident that the proposed legislation to militarize occupational therapists is the only solution to their maintenance in the military service. Remaining to be considered, therefore, is the question of whether we are willing to accept the responsibilities implied in such a step or whether we prefer instead to forfeit all that has been gained and the progress that has been made at such expense. Being the decision of the Surgeon General, based on his personal appraisal of the value of occupational therapy as he saw it in hospitals in this war, and not the achievement of any lobbying group from within, this acceptance "to the ranks" seems of the utmost significance and an unmistakable tribute to the entire profession. It is one which we cannot fail to recognize and, ultimately, accept.

In conclusion, I would like, on behalf of the Surgeon General and the entire Army Medical Department, to thank the National Office, the directors and personnel of the schools whose support and complete cooperation have been, in large part responsible for whatever success the Army program may have realized. Without their interest and help, the job could never have been done. Likewise, sincere thanks and appreciation are extended to every occupational therapist who served with the Army during the war years. As the Army wins its battles only by virtue of its soldiers in the line, so must the occupational therapy programs of this war be credited to the therapists who made them. Individually and collectively, they are the ones who have made the mark.

And finally, to one Army occupational therapist in particular, the heartfelt gratitude of everyone associated with the profession is long overdue. We who were privileged to work with Mrs. Winifred Kahmann, O.T.R., in the program she organized and directed know that without her untiring efforts and constant inspiration our story could not have been told.

Miss West's paper is a continuation of the report contained in the April issue.

State Association Programs

SUSAN S. BARNES, O.T.R.
Director of Occupational Therapy, St. Louis Society for Crippled Children

The program chairman of most State Occupational Therapy Organizations finds herself with a big task ahead when she takes over her duties, and she has little time to devote to this added responsibility. She has usually been selected because of her knowledge of community resources, and/or because no one else would serve. She has been assured that the group will give her every assistance in carrying out her program, but it is the program chairman who must do the initial planning and carrying through. This calendar is merely a suggestion and outline that may prove helpful. Local and national community interest will be stimulated and a great source of fresh material and information made available if programs coincide with the months designated by national organizations for their publicity and drives or just following them. The programs listed are suggestions that could be used in correlating the calendar of national dates of allied activities with a program for occupational therapy organizations. It would be of value and interest to hear from state associations in the Letter Column when they have a particularly well planned and stimulating meeting.

It is suggested when planning the monthly programs that each national and local organization be contacted for their latest publicity and educational material.

SUGGESTED CALENDAR—CORRELATING COMMUNITY AND NATIONAL DATES

CALENDAR	SUGGESTED PROGRAMS
January Poliomyelitis— "Miles of Dimes"	Evaluation of O.T. in relation to Poliomyelitis, Agencies in the community serving the Poliomyelitis patient. Exhibition of chart analyzing projects to be used as modalities in O.T. treatments. A joint Occupational-Physical Therapy meeting.
February National Heart Week February 14-21	Agencies in the community serving the Rheumatic Heart Child. An Occupational Therapy program for the Rheumatic Heart Child—in the hospital—at home. Children's Bureau—National Resources for the Cardiac Child.
March American Red Cross	Activities of Junior Red Cross—use of their services in an Occupational Therapy Program. Grey Ladies in hospital program. Red Cross Arts & Skills Programs — Evaluation in wartime — peacetime.

STATE ASSOCIATION PROGRAMS

April National Society for Crippled Children and Adults Easter Seal Drive	The program of the National Society for Crippled Children and Adults. The program of Local Societies for Crippled Children. Cerebral Palsy—secure outstanding speakers from the field of Medicine, Physical Therapy, Speech, Occupational Therapy, and Medical Social casework.
National Cancer Week	State Cancer Program.
May Mother's Day, May 11 Father's Day, June 15	Study of community resources for the aged. Business meeting.
June Puppeteers of America Annual Festival	Demonstrations of techniques of puppetry. Exhibits of foreign puppets and local material. Analysis of puppetry as a modality in occupational therapy.
National Recreation Association	Group recreation.
September (V-J Day, August) Veterans' Administration Army & Navy Hospitals	The Retraining Program in Veterans' Administration Hospitals—Occupational Therapy in peacetime Army & Navy Hospitals—physical set-ups—staff—general program—specialized treatment programs.
October Hire the Handicapped Week Oct. 17	Review of agencies in community serving the handicapped. Field trip to industries employing the handicapped. Joint meeting with local agencies for handicapped. Legislature affecting the handicapped—Vocational Rehabilitation.
National Hard of Hearing Week	Demonstrations of hearing appliances. Demonstration by local hard of hearing group.
November Community Chest Drive	Visits to local agencies in the health group of the Community Chest. Program planned around an agency whose services are used by the Occupational Therapist. Are all available facilities of the community being used in the Occupational Therapy program? Case presentations by Occupational Therapist.
December Tuberculosis Christmas Seals	Rehabilitation programs for the tuberculosis patient. Occupational Therapy projects and programs for the tuberculosis patient.

REFERENCE SOURCES

Organization	*Address*
American Cancer Society	350 Madison Avenue, New York 17, New York
American Foundation for the Blind	15 West 16th Street, New York 11, New York
American Foundation for Mental Hygiene	1790 Broadway, New York 19, New York
American Hearing Society	1537 35th Street, N. W., Washington, D. C.
American Heart Association	7790 Broadway, New York 19, New York
American Rehabilitation Committee	28 East 21st Street, New York 10, New York
National Foundation for Infantile Paralysis	120 Broadway, New York 5, New York
National Recreation Association	315 Fourth Avenue, New York 10, New York
National Society for Crippled Children and Adults, Inc.	11 South La Salle Street, Chicago 3, Illinois
National Tuberculosis Association	1790 Broadway, New York 19, New York
Puppeteers of America	600 Merchant, St. Louis 4, Missouri
Veterans' Administration	Washington, D. C.

Geriatrics and Occupational Therapy

By GRACE C. HILDENBRAND, O.T.R., SUPERVISOR
Occupational Therapy Department, New York City Home for Dependents, Welfare Island, New York 17, New York

It is now a well-known fact that the number of aged in our population is steadily increasing. The future years will find our civilization consisting of more aged persons as statistics are already showing. The human span of life has risen from an average of forty-two years in 1900 to sixty-five years in 1940, and the same source of statistical information points to the fact that in this country, alone, some ten million aged constitute a great factor in our socio-medical problems. That this number, too, will increase to twenty-five times as our aging population increases is predicted for us and will take place within the next five decades. From these figures, alone, is indicated the importance of focusing our attention upon the needs, the scientific care, the health and medical problems of the aging and the aged. This field of specialization is known as Geriatrics. It takes into consideration not only a mere study of the aged and their problems but, for those who give the subject closer and more careful attention, a fuller realization as to the true meaning of Geriatrics is revealed. It deals, also, with the health of the aging, the medical problems of those who are normally aging, and the mental and physical illnesses that bring on premature old age.

We understand that in the process of aging there is a gradual senescent degeneration of the body as a whole. This, in turn, brings on phsiological changes in every organ and tissue of the body. Hence, the primary object of Geriatrics is not only to increase the span of life of an individual but also to assure the aging one of better health, a life full of vitality with proper physical functioning, and to reveal the important part played by the mind, as well, in all this humanitarian endeavor.

In the process of aging the functions of the bodily organs and tissues are altered. We learn that the greatest physiological changes that take place are the gradual retardation of cell division and of tissue repair, a decrease in tissue elasticity, atrophy of the cells, a diminishing in the strength of the musculo-skeletal functioning in general, and an insidious progressive degeneration of the entire nervous system. We are all aware of the more usual characteristics of aging: poor circulation, dryness of the skin, graying of the hair, baldness, impairment of the vision and hearing, tremors of the hands, and loss of teeth, are among some of the more familiar manifestations associated with old age. With the physiological changes come slight mental disturbances; lapses of memory, forgetfulness of names, wide linkage between ideas, stalling in conversation, are a few of the more apparent disturbances. There is, also, usually present an increasing tendency to conservatism, difficulty of sustained attention and concentration. In addition there may be an emotional and social decline; that is, the aged tend to withdraw into themselves and they tend to become more individualistic. In old age one is likely to find attitudes of anxiety, moodiness, sensitiveness, and unwarranted suspicions. The general senescent degenerations often make the older person feel more fearful, bewildered, and isolated.

To age is to change and this we know is a continuous process in life. So-called degenerative diseases start without immediate symptoms being noticed. Because of this insidiousness they may progress many years before subjective complaints are staged. At this point the disease has usually reached its chronic stage. As a rule these degenerative diseases entail a long period of increasing disability and invalidism.

We find that the causes of death among the aged are primarily diseases of the circulatory and respiratory systems and the kidneys. Among the circulatory diseases we can name cerebral apoplexy, arteriosclerosis, cerebral thrombosis, and cardio-vascular renal diseases. Included in the respiratory diseases are acute

lobar pneumonia or sub-acute bronchopneumonia. Mental diseases, though, are responsible for the more prolonged or progressive disability.

Individuals of sixty-five years are often referred to as having outlived their usefulness to society. However, we know from our own individual experience that they often do prove of invaluable assistance to the intellectual growth of the young around them. The aged constitute a marked influence in our civilization. We have, only, to remember and refer to the work which thousands of our aged performed during our late war emergency. It has been decidedly proven that they worked efficiently and were considered quite capable despite their advanced years. Who would gainsay the fact that their philosophical wisdom of a quiet peaceful nature is a worthy contribution to a civilization so transitory as is the one we now live in?

A quaint story is told of how it was once the custom in Asia Minor to take the aged folks to a cave in the woods away from the immediate family surroundings so that the remainder of the old folks' life could be lived in the peace and quiet his nature craved and, of course, be out of people's way.

Preparations were being made to take an aged grandfather to the Cave of The Old Ones from which none returned. The head of the household bade his young son to bring a large woolen blanket for his grandfather. The broken-hearted lad, obedient to his father's request, brought the "chull" as it was called, but neglected to say that he had cut it in two and left the other half in the house. When the grandfather had been duly disposed of with proper filial respects, son and grandson returned home from the Cave of The Old Ones.

Later, the father discovered the other half of the "chull" in the house and exclaimed, "Look what you've done. Everyone will say we were too stingy to give grandpa the whole blanket!" "No, father," the lad replied, "I wasn't being stingy, but I thought it was better to give grandpa only half . . . . then later I could give you the other half."

Needless to say, this shocked the father to the point of bitter weeping and upon recovering he said to his son, "Come, let's go back to the cave and bring grandfather home."

The moral of this story is too evident to need explaining, but our own socio-economic conditions are such that the keen competition often forces persons of sixty years or so to retire from industry. This enforced retirement should provide means for directing the individual's interests into channels of leisurely expression. Eventually, many individuals, because of unfortunate circumstances, must rely on retiring to a public institution for the dependent aged. Adjustment to this mode of living is not too acceptable to many; since they, already, feel insecure, lonely, and depressed. By assigning these people to some active interest or teaching them new techniques, a stimulus is provided whereby the mental and physical forces that are latent may be aroused to renewed activity and accomplishment. Idleness and lack of purpose are the greatest enemies of the aged. All physicians know how contributive a factor mental tension is to the ill health of the body and that by removing this tension the body is often enabled to function better.

Not only is it the aim of Geriatrics to prolong the life span of an individual, but it also aims to help the aging one to enjoy his life in better health and vitality, and to help the individual in the adjustment of his personality to senescent changes. Occupational Therapy plays an invaluable part in fulfilling this latter aim of Geriatric Medicine. Again, it should be stressed that idleness and lack of purposeful activity are the greatest enemies of the aged, since these factors encourage mental and physical deterioration and invalidism.

In any well organized and properly functioning Home for the Aged, it is possible for each individual to find a channel of expression whereby absolute enjoyment of leisure is attainable with the freedom to choose his or her own field of endeavor. It is in the Occupational Therapy department that a wide and varied program of challenging craft techniques are made available under the supervision of a well-trained therapist. Through the individual's own effort, normal patterns of life and expression are made possible. In many instances possible neuroses are prevented, morale and self-respect of the individual are maintained.

Cheerful shops, away from the wards, where mixed groups can meet and mingle, where an abundance of activity, whether it be craft techniques, photography, gardening, newspaper work or ceramics, is made available and graded to meet individual mental and physical ability. They provide a soul-satisfying haven where the aging and the aged, where the infirm and the handicapped are welcome to enjoy in utter happiness and freedom their enforced retirement from the socio-economic world. The completion of an attractive article gives the worker a distinct psychological lift. What accomplishment of a constructive nature does not? Encouragement is substituted for discouragement; the handicapped soon learn that they are not, thereby, made incompetent; and by building up morale and by inculcating a sense of group responsibility, adjustment to institutional life is made more acceptable.

Dr. William King, Director of the Division of Adult Hygiene and Geriatrics of the Indiana State Board of Health, once expressed ideas to the effect that old age is neither a visitation nor a penalty, but rather an accomplishment and fulfillment; that it need not be just endured, but rather that it can be enjoyed. And, thus, it is for Geriatrics to aim not only at increasing the span of life of the individual but also to assure the aging person of better health so as to be able to make the adjustment of his personality to senescent changes and prove of further usefulness to society.

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Allied Professions

NEXT STEP — A SUITABLE JOB

By JEAN MCNARY, *Counselor*

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Considerable progress has been made in the last decade in the successful placement of men and women who are occupationally handicapped. Like all real social progress it is the result of intensive work of a host of people in a score of professions, each making its distinctive contribution. Great strides have been made in medicine, occupational therapy and physical therapy in assisting people who are handicapped by injury or disease to return to the level of a normally productive life. Parallel developments have occurred in soundly standardized tests, industrial job analysis, occupational training, usable labor market information and selective job placement.

The vocational counselor who serves the former patient as he lays plans to become the future employee is a sort of middle man in rehabilitation. From this point of vantage it is heartening to see the progress made but it is awesome to see the job ahead. People who are occupationally handicapped are having a stout time getting suitable work at a time when employment levels are at the highest in our history. Considered studies are agreed that we have not yet found a way to maintain that high level of employment; at the same time we find the trend of handicapped workers re-entering the labor market is at a steady increase. If they are to get work it is going to take planned cooperation of everyone who serves them from the time of injury or illness until they are settled and producing in a suitable job.

Any short discussion of the placement of handicapped workers risks oversimplification and confusion of terms. But it is worth this risk if it helps people in coordinate services to see their part in a plan for rehabilitation.

We start with the fact that we are considering an individual who has reached an employable level. Basically he wants to work to build security for himself and his loved ones. To be a satisfactory job it must provide for food, shelter, protection and recreation and it must at the same time fill his need for a sense of accomplishment, for status, and for social well-being. It follows that rehabilitation starts with the premise and ends with the fact

of suitable occupation within the limits of each disabled person.

The part of the vocational counselor is to help him make a realistic job choice. It is not enough to select an occupation, there must be a job he can get and an orientation in that job that he can successfully complete. A tiny proportion of handicapped workers are employed in sheltered workshops; another fragment go into the pauperizing jobs that play on human sympathy. But the overwhelming majority with reasonable employability go into the competitive labor market. In the long run employers pay men their economic worth; it is unimportant whether they are disabled or not. The old emotional plea to "hire the crippled" failed because it was poor business. What is more, it exploited the individual. The thing we have finally learned in America is that it is good business to employ workers for suitable jobs. Tremendous sums are saved in training, turn-over, and absenteeism. The fact that a man is disabled need not mean he is occupationally handicapped if he is suitably placed. Those of us working with men and women who have a disability have a clear responsibility. It is to help handicapped persons to know what they can do with their residual abilities. Of course they must learn to know their limitations, but that is not for what employers pay them.

Early in the war the United States Employment Service organized the thinking and experience of industrial and rehabilitation leaders in a Selective Placement Program which has been continued since the war by the State Employment Services. With suitable adaptation it was and still is being widely used in industry, civil service and rehabilitation programs. The concept is the simple practical business process of job analysis in terms of the physical demands. A deliberate analysis of each job with all its variations shows required physical activity of fingers, hands, arms, legs, weight-bearing, speech temperature changes, etc. A similar chart is completed for an individual noting ability, limitation, or contraindication in each of these job factors. It is called a potential employee's physical capacity. It is that physical capacity that the individual trains and grooms to the limits of his abilities and takes to the labor market as a salable asset.

In helping a disabled person make a suitable job choice the vocational counselor marshals relevant facts and organizes them for the use of the individual. He has measurable intelligence and aptitude; there is an established history of work experience and training; his is a known responsibility in terms of home and family; he has a given physique and appearance; and he has reasonably predictable physical capacities. The individual is going to enter competition in a current labor market where supply and demand and requirements for job entry form a changing and confusing pattern. No plan will make any sense unless it is based on labor market information at that time, in that locality.

A second and much more difficult part of the counselor's job is more intangible. The test profile, the check list, the budget, the physical capacities appraisal, and the labor market facts are useful tools, and no more. The personality of the man, woman, or child cannot be put down on paper, nor can his adjustment to his disability, or his emotional maturity, or the measure of prejudice he will meet in the community. It is well to be suspicious of any vocational counsel plan that looks too pat and pretty. Human variables cannot be caught in a static picture. Anything that appears to be one is not more than a stroboscopic glimpse.

In looking forward with the patient to a future of suitable employment the occupational therapist makes a substantial contribution of which she is well aware. Beyond that it is my plea that she can assist the vocational counselor in two very specific ways. She can be a great help in establishing physical capacities. It is important that a disabled hand can finger objects over an inch in diameter, or that a grasp is effective up to five pounds. It makes a difference if a man is unaffected by constant noise, but strained by sudden or sharp noises. It matters if a person with an amputation has reached a tolerance of two hours standing and walking, bearing weights up to fifteen pounds. These are the physical capacities the patient, the doctor and the employer cannot express. The occupational therapist is in a position to

determine these factors and many more over the period of time she works with the individual in the hospital or curative workshop. She can learn what facts are pertinent and of significant value. If she will get these facts to the counselor, the training officer, the employment interviewer, or someone along the way, the odds of suitable placement are substantially raised.

The second contribution of the occupational therapist is the observation of tangible factors. The patient's response to pain if it is to be continuing, his ability to get along with others, his care of tools, and scores of other factors can be passed on to the counselor — always with the approval of the patient and doctor, of course. These are the factors that add up to success and failure on the job. The girl who has not learned to get along with people is not likely to learn to do so in her first job after being disabled. A job is not treatment; it is a competitive produce-or-else situation. She might be equally qualified for a photography dark room job or for work in a typing pool in a publishing house. The odds of success, however, are not the same. The occupational therapist's observation can help the counselor show the difference in those odds to the girl who has that choice to make.

There is a contribution that the counselor can make to the occupational therapist that must also be developed. No one can know the physical demands of all of the thousands of occupations. Surely the occupational therapist cannot hope to. Nor can she be close enough to the labor market in a community to know the specific demand for jobs. In some localities the welder who loses an arm at the shoulder is not occupationally handicapped if he makes reasonable progress in adjusting to his loss. He can go into a job laying an oil tight bead on tacked mild steel, a process in the manufacture of ordinary oil tanks. In another community there would be no welding job that he could fill. Surely his early rehabilitation plan must be based on realistic facts.

There need be no organized program to start this two way flow of information between the occupational therapist and vocational counselors, rehabilitation workers or industrial personnel staffs. The accumulated information pertinent to a given patient exists; it needs only to be tapped by telephone. Many therapists and counselors have been working closely for years. The important thing for us all to remember is that we cannot afford to ignore any valid source of facts if we hope to be of maximum service in speeding the potential worker's rehabilitation.

* * *

The following reference material might help the Occupational Therapist become familiar with the physical capacities information that is useful to the vocational counselor or placement staff:

Selective Placement for the Handicapped—United States Employment Service, Washington, D. C. Revised 1945:

Includes: Summary of the analysis of Physical Demands for a job and of Physical Capacities Appraisal for a potential employer; Analysis of specific disabilities and their occupational significance; bibliography of other source material relevant to placement of handicapped workers.

National Physical Demands Information Service: No. 1 Apprenticeable Occupations—United States Employment Service, May, 1945.

Sample Physical Demands Analysis in a wide variety of occupations. . . . It shows what factors are important in evaluating a job or a prospective employee.

Good bibliographies of government printed material: "Occupational Monographs Available through the Federal Government," Walter J. Greenleaf, *Occupations*, April, 1947, p. 388. *Guide to Counseling Materials*, United States Office of Education, Washington, D. C., May, 1945. United States Government Printing Office. *National Job Descriptions Index*, United States Employment Service, Washington, D.C., Revised July, 1946. (mimeo.)

Specific information about any job is available. The material is so copious it would be impractical to accumulate it all unless a great deal of counseling and job placement is anticipated. If an Occupational Therapist wants a description of a job, its physical demands, or its availability in a community, she can get that information at the State Employment Service. The employment Counselor will be glad to aid with suitable placement when the patient is ready to re-enter the labor market.

OCCUPATIONAL THERAPY

A Point of View

By BARBARA B. STIMSON, M.D., F.A.C.S.

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Associate Attending Surgeon, Presbyterian Hospital and Vanderbilt Clinic

"Doctor, I've finished it," and from a bedside table is proudly pulled a gaily painted wooden horse. The creator of the horse was a man with a badly injured right hand and wrist and the toy, destined for his small son, had taken him days of painful effort. But the satisfaction of accomplishment and the realization of regained usefulness were worth all the hours of struggle. When he had started to work he could barely get his fingers around the largest handle in the shop but when he finished he could hold a paintbrush. There were days of discouragement when he was sure he couldn't do it but there was a skillful therapist to encourage him and his son's birthday was drawing near.

Occupational therapy has as its underlying purpose, the regaining of coordinated muscle action to accomplish something, to do something. Muscle strength as an end in itself is a useless thing unless the patient is the strong man in the circus. Muscles must be strong in order that the patient can be able to lift, to carry, to walk. But strength without coordination is useless. From infancy, when the first grasping movements were made, habit patterns of coordinated muscle action have been established so that man can walk, dress and feed himself and do his daily work without having to use his mind to control his muscles. If he had to stop and think which muscle to contract in order to lift his foot to take a step he wouldn't walk far. In the normal daily life thousands of skilled acts are performed without a conscious thought as to how or by what muscle groups they are accomplished. Sufficient is it that the necessary act is done.

Should an injury occur, however, the pattern is lost. Depending on the severity of the injury, on the treatment required and on the character of the patient, that loss may be of short duration or prolonged. If a bone has been broken and splinting necessary, the muscles of the injured extremity will be stiffened by infiltration with hemorrhage and edema and weakened by disuse. When the patient attempts to use the limb it no longer responds with the normal coordinated muscle action. A conscious effort is required to contract the muscles and frequently nothing happens. If there is some ache or discomfort associated with the attempt the patient may be easily discouraged and stop trying or he may substitute normal muscles. A striking example of this is seen in the patient with an injured shoulder who, when told to raise the arm, uses his scapulo-thoracic muscles without moving his humerus in the glenoid one degree.

With the physical disability comes a feeling of frustation. Not to be able to do the simplest act like eating because the muscles don't respond is a deeply disturbing and discouraging discovery. And usually the harder the patient consciously tries the more unsuccessful he is because every muscle goes into spasm. His face becomes covered with perspiration, he clenches his fist and tightens his jaws and nothing happens. If, however, he relaxes and then is asked to touch something or to reach for something, that habit pattern begins to reassert itself and the extremity may start to move smoothly to accomplish the desired result.

Occupational therapy, therefore, must strive to reestablish the broken habit pattern by fixing the patient's mind on what he is doing, not on how he is doing it. The satisfaction of the completed object is very important and should not be overlooked in the endeavor to provide the patient with the exercise necessary for his particular injury.

There are certain dangers which must be guarded against by the watchful therapist. The

From the Fracture Service of the Presbyterian Hospital and the Department of Orthopedic Surgery, College of Physicians and Surgeons, Columbia University.

first is substitution. It is human nature to do something the easiest way and to avoid using muscles that are weak and lame. In his eagerness to complete a job a patient with an injured extremity is frequently extremely ingenious in avoiding the use of just the mechanism that should be exercised. A second danger is over-use. The tendency to force tired, aching muscles to keep on past the efficiency point is frequently observed in the over-ambitious patient and can be avoided by changing the particular occupation. Under-use is also to be watched for. Coordination and strength gradually increase and the movements a patient found difficult at first become gradually easier until no further progress can be obtained unless he moves on to something more difficult. The requirements of the job must be carefully watched for nothing is so discouraging as to attempt something completely beyond a patient's power, nor so boring as to keep on doing something that has become mechanical.

Herein lies the skill of the experienced therapist. She must find an object, the making of which will exercise the weakened muscles progressively and the finishing of which will be a satisfaction to the patient. Weaving three or four rows in a rug may move the injured extremity but unless that rug is a community endeavor for some recognized use the mental stimulus is gone. A smaller project completed entirely by the patient, even if in its completion he may use some normal muscles occasionally, is far better. To find such appropriate objects in woodwork, metalwork, pottery, etc., taxes the ingenuity of the therapist.

Because the therapist is dealing with a human being with an individual injury she must avoid the danger of sterotyped activities. All Colles' fracture cases should not be given the same basket to weave. The individual and his mental as well as his physical requirement must be carefully studied. That requires tact, a knowledge of human beings, and intelligence, as well as a working knowledge of as many crafts as possible. She must know not only what his injury is but also what functional demands will be made on the injured extremity when the patient returns to his normal activity. Is he a violinist or is he a manual laborer? Does he need finger dexterity or is strength more important than flexibility?

Much has been written recently of the advantages of occupational therapy in teaching new crafts and in discovering hidden and unsuspected talents. There can be no doubt that this is important, particularly in patients who cannot resume their previous occupation. But in civilian hospitals these cases are in the minority and care must be taken not to lose sight of the main objective, that of reestablishing normal coordinated muscle response as quickly as possible in order that the patient may return to his former life in the community without handicap.

Is is not within the scope of this article to discuss the specific crafts suitable for each fracture. The doctor should discuss the individual problem with the therapist as often as is necessary. It is in her province to work out the details. She must find the means to provide the needed progressive use of the injured extremity and the essential mental stimulus as well. Her job is a hard one but challenging. She cannot work alone. Only by the cooperation of doctor, therapist and patient can the best results be obtained.

Employment for the Disabled in Britain

By JOHN HALL

It was two o'clock one morning in August, 1944. General Bradley's First American Army and General Patton's Third Army were racing deep into France after the Normandy break-out and the British forces, loose from Caen, were on the move towards Falaise.

Ted T. Ruck, 20-year-old corporal in the Dorsets, one of the English county regiments, was up front on patrol. In the darkness one of his squad stumbled into a trip-wire.

Corporal Ruck did not see the flash or hear the bang. When the medics reached him there was a jagged piece of teller-mine in his forehead and his right leg was useless. He lived—just.

It was a year later that Ted Ruck left hospital, returned to his home in a South Wales mining valley—and started wondering about his future. He was shaky. His leg made it impossible for him to return to his old job as a heating engineer.

At 22, Ted Ruck found himself one of Britain's war disabled, one of an "army" of men smashed in battle, and men and women smashed in the blitz bombing, the human wreckage of war. Ted Ruck handed his mustering-out pay to his young wife, explained to her his disability pension—$11 a week. On a comparative basis of living costs it was equal to a G.I. with a pension of $25 a week, not a lot for a family man.

PAID DURING TRAINING

What to do? South Wales is a center of heavy industry—steel and coal—not many "light jobs" there. Ted Ruck went to Britain's Ministry of Labor. They told him, "A new scheme has been started to help chaps like you. We will get you a job, a job you can cope with."

They did.

Today Ted T. Ruck belongs to a growing army of British "Purple Heart" veterans who are being given a new life. He leaves home every week-day morning and goes six miles by 'bus to a factory at Bridgend, Glamorgan. It used to be a shell-filling factory. Now it is called a Remploy factory. There he joins 100 other men and a few women, all disabled, who are doing "light work." Ted Ruck has become a leather worker. He makes bill-folds and ladies' handbags and a 44-hour week earns him $19 to add to his $11 pension.

Today Ted Ruck will tell you, "I am nicely off. Who would have thought it? Before I left hospital I felt I was finished—just a wreck. That Jerry mine stopped several of my buddies for good, and often I felt it would have been better had it stopped me too."

Across the work-bench 29-year-old Miss Gladwyn Stoneham smiles as she listens to Ted Ruck. Then, in her sing-song Welsh, she tells about her bomb-crushed left leg. She was brought back after being sure she would spend the rest of her life at home with her widowed mother. Gladwyn is now earning $12 a week, which is a good wage for a woman in the mining valleys of South Wales. Ted and Gladwyn and all the other workers at the factory were paid during their training periods, and now earn very close to the standard trade union rates for the jobs they do. And if their weekly commuting tickets cost them more than 70 cents the factory pays the excess.

"Remploy" is short for re-employment and the Remploy factories are the latest step in a national plan to provide disabled British workers with work they can do. The Remploy factories are only for severely disabled persons but the over-all plan covers all forms of disablement handicapping a worker to the stage when he or she cannot compete for jobs on level terms with the fit and healthy. It covers everyone over the age of 16, whether they were born with a disability, are industrial casualties, were war-shattered, and even the jay-walker crippled by a skidding taxi. In the factory where Ted and Gladwyn work there is an old miner. He is 56. In 1918 he lost one leg and had the other leg crippled. From 1919, when he left hospital, until last year, he was "derelict." He is now one of the best French polishers at the Bridgend Remploy factory and declares he is going to catch up "on those 27 years I wasted."

The Remploy plan is administered by a private limited company called the Disabled Persons Employment Corporation Ltd. The Corporation was set up by Britain's Government, and is financed by the Government. It is non-profit-making. Four factories are already operating and six more are to be opened shortly. If all goes well there will be 80 by the end of 1948 and still more to follow.

The work ranges from leather craft, toy-making, woodwork, French polishing to light assembly work.

The Bridgend factory has a sub-contract with a big firm to assemble automobile dashboard gadgets and another to assemble dashboard lighting outfits.

The men who run the Remploy plan emphasize that it is not a relief scheme and it is not charity. They say, "We are providing the opportunity for people who cannot compete on level terms in industry to do a useful job and earn a living. Remploy is for the most severely disabled and will employ thousands of men who would otherwise just brood their lives away. Naturally many of our people will be ex-soldiers and they have priority, but it should be clear that Remploy is another stage in the over-all plan to help all disabled people in Britain. The full plan covers everyone."

Jobs Reserved by Law

Cornerstone of Britain's drive to give equal chances to its less fortunate citizens, whether they have been handicapped from birth, injured in or out of industry, or war wounded, is this—however much a man or woman is disabled, unless they are total cripples or bedridden, there is some useful job they can do. Put them to work and everyone benefits. Visiting Americans have described the plan as one of the most far-reaching schemes of social legislation of the century. The Remploy factories will, in time, provide work even for those who are home-bound.

Disabled people like Ted and Gladwyn are easy to locate. In these times records are complete and in the case of an ex-soldier there are veterans' associations which keep in touch with men like Ted. There are thousands of people who are disabled but their disability is so slight that it is not a handicap and it is often kept strictly secret. They do not concern the Government unless their disability increases and they have difficulty in finding employment. The over-all plan covers the less fortunate, and these less fortunate are asked to register themselves. At the end of 1946 there were 730,000 names on Britain's "Disablement Register." They included 115,000 casualties from World War I, numbers of industrial casualties and, of course, many of the disabled of World War II.

There are not many people on this register who are workless. In 90 per cent of cases the British Government has been able to carry out its promise, "Come to us and we will find employment for you."

It was in this process that the need for new factories exclusively for the new war crop of severely disabled became apparent — and Remploy was started. It fills the last gap by absorbing men and women so obviously handicapped that private employers fight shy of hiring them.

Before Remploy there were, and still are, two aids for the vast majority of the disabled, that is those who are capable of work under ordinary conditions. One is the fact that the occupations of car-park attendant and elevator operator are reserved by law for registered disabled persons only. Britain, however, is a country where there are thousands of free car-parks and comparatively few elevator buildings. The provision which has been of greatest service to war and peace disabled is a law which compels every employer in Britain who has a staff of 20 or more persons to hire at least three per cent of disabled persons. That is the law in Britain and it is a law which has given employment, hope, and a feeling of usefulness to thousands of less fortunate people.

It is a law which has worked well. But the Government was not satisfied. They saw the hospitals turning out the crop of disabled from World War II, men and women like Ted Ruck and Gladwyn Stoneham. Experience from the rehabilitation centers showed that thousands would have to be "nursed" along — to throw them back into ordinary life and leave them to go seeking jobs, handicapped as they were, would mean that large numbers would fall down on the job.

So the Remploy factories have been started to make the grade for Britons like Ted and Gladwyn, who are too seriously handicapped, to make the grade themselves.

Coordination in Medical Rehabilitation in Veterans Administration

By HORACE SPAULDING

Shop Retraining, Department of Medicine and Surgery, Veterans' Administration, Washington, D. C.

An entire new field has opened up for Occupational Therapists which is really progressive. This work wields a tremendous influence on the futures of disabled veterans in VA hospitals.

This new field might be called "Conditioning Therapy." It has been made possible by the establishment of the Shop Retraining Program in the Medical Rehabilitation Service and by the installation of the Vocational Advisement and Guidance Service in the VA hospitals.

The records show that in many instances the failure of Occupational Therapists to condition patients has seriously increased the problems of the Shop Retraining Instructor. Many patients who come to the Shop have not been conditioned physically or mentally to the point where retraining work can be successfully launched.

When the patient cannot manage these retraining operations he gets discouraged, and loses interest. This is particularly evident in pre-vocational watch repair where the work is so delicate that the conditioning of nerves and muscles is essential for success.

This same "conditioning" is vitally important to the work of the vocational advisor also. In order to give proper counseling he too must deal with a calm, rested, coordinated person who can display his aptitude without having the results affected by shaking nerves and sweaty hands.

Highlighting the Shop Retraining Program is a watch repair project. Although this is only one segment of the VA Medical Rehabilitation Program it is a fine illustration of the need for conditioning therapy. It is known as the Bulova School of Watchmaking.

Breaking away from traditional methods of teaching a skilled trade, those who designed the course divided it into many individual training units. Each unit represents a major operation or a series of operations. Colorful diagrams, still pictures, colored films, and animated sound movies give life to what would otherwise be monotonous description.

Perhaps the outstanding unit is the preliminary one designed to make the student accustomed to working with the small tools and materials of the trade.

Starting with round plates which have fifty holes to a plate, the veteran first learns how to insert small screws into the plate without marring the screws or scratching the soft plate surface. After progressing through several stages from large to small screws the veteran is then taught how to remove and replace balance screws from balance wheels. Starting with a pocket watch size the student works down to the balance wheel screw of a baguette watch. Through all this the student is graded. It has been definitely proved that if a student passes this preliminary training unit with good grades and if he is fascinated by the tedious detail required he can do creditable work in all mechanical phases of watch repairing.

The Bulova School of Watchmaking has donated training facilities and materials to the Veterans' Administration Medical Rehabilitation Service in order to establish pre-vocational courses in six paraplegic centers.

The instructor is sent initially to the school for a two weeks' orientation course in techniques. As a follow-up the school sends its instructors to the hospitals frequently in order to get more advanced information to the pre-vocational instructor. All hospital work is graded, and the results are sent to the school. Upon discharge from the hospital the paraplegic can apply for training under Public Law No. 16 and enroll in the school at Woodside, New

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York, receiving credit for the work he completed while in the hospital.

When he graduates the VA gives him approximately $500 worth of tools and equipment with which he may establish his own repair shop. If he chooses he may accept one of the many jobs offered to the school graduates by jewelers throughout the country. The salaries range from $75.00 to $125.00 per week.

There are now over 100 paraplegics working in the hospitals on the preliminary course, 30 of whom will be enrolled in the school at Woodside by June 1st.

Now let us see where you Occupational Therapists fit into this program. As mentioned earlier your efforts are the initial ones and precede the aptitude testing and counseling of the vocational advisor. Your conditioning of the patient is the key to his success in pre-vocational watch repair work.

Records show that nearly everyone of the seriously interested paraplegics who has actually begun watch repair work and who has intently carried on from day to day, has had a thorough Occupational Therapy training history behind him.

Perhaps he is the patient who waited at the door for you to open up, and the one who complained when you ran short of materials. You saw him progress from project to project under your guidance. Possibly he is the patient on whom you had to use all your persuasion and tactics before you gained his interest, but that interest once gained has been yours.

Regardless of the manner or method by which he became your patient, remember this one point: A patient who has spent a long time in bed must regain (through Occupational Therapy) delicate control and dexterity of his fingers (in coordination with calmed nerves) before he can do intricate or detailed work.

Unless the patient is "conditioned" to the pre-vocational watch repair course the chances of his discouragement and resulting loss of interest are great. With this in mind it is vital that the Occupational Therapist give serious attention to a patient's pre-vocational interests.

For the same reason each patient who seeks counseling from a vocational advisor should first have a background of Occupational Therapy. It is obvious that a display of nervousness while performing mechanical aptitude tests would directly affect the score of the patient and might confuse the counselor's judgment. By conditioning the patient to the re-use of his hands and fingers an O.T. is giving vital help to both the patient and his advisor.

General Omar N. Bradley, Administrator of Veterans Affairs, has recently approved the expansion of the Bulova Plan into certain tuberculosis hospitals. This new program would be especially arranged for tuberculosis patients.

Under the new plan for tuberculosis patients each hospital will have a two-part pre-vocational watch repair program. (1) There will be an established shop with an instructor in which pre-vocational training will be given to ambulatory patients. (2) Under supervision and instruction of the watch repair instructor the Occupational Therapy Department will develop the bedside program.

During this bedside period each patient in the course will be issued his own tools and a table-over-bed with a specially designed top. When the patient becomes ambulatory he will be turned over to the instructor in the shop to continue the course.

During the bed training period the shop retraining instructor keeps in close touch with the patient's progress so that when the patient reports to the shop his background and abilities are already known.

This coordinated plan of continuous retraining in the watchmaking field is large in its scope. However, it serves as a fine example that other trades may follow in developing similar methods on a local or national basis. Many are inclined to ask: "Where does the Occupational Therapist stop and the pre-vocational shop retraining instructor begin?" The answer is: the jobs actually overlap. However, the Medical Rehabilitation Service emphasizes again and again that the first job and a most important job is that of the Occupational Therapist. It is the Occupational Therapist who must see to it that a patient (who has spent a long time in bed) be given careful and thorough occupational therapy activity in order to develop the dexterity, coordination and calm nerves required of him for intricate and detailed work.

HIGHLIGHTS OF EXECUTIVE COMMITTEE MEETING

Because of the time factor involved, presenting current material in a bi-monthly publication is difficult to achieve since oftentimes the dates of the A.O.T.A. Board and Executive Committee meetings coincide with the approximate dates at which A-JOT goes to press. Thus, these official reports must be carried in the issue of the Journal immediately following the meeting dates.

Where such conflicts of dates occur, A-JOT will carry where possible summaries of the meetings in the issue preceding that which carries the official reports.

In this issue will be found the official reports of the Board and Committee meetings which were held in Philadelphia in March. A summary appeared in the April issue. Following are highlights of the recent meeting of the Executive Committee held at the New York office June 3.

Discussion of the financial condition of the Association consumed the majority of time. In this one year we assumed more responsibility than it has ever before been necessary to shoulder in a comparable period. A-JOT, our official publication, is now owned and edited by the Association. The Public Relations program was a necessity at this time, and there has been a compelling demand for a long time for the Educational Research Program. Each one of these major projects involved heavy financial commitments, but all were necessary to continue our comparative standing with other groups in the medical profession.

Finances are such that the moving of our national offices to Chicago at this particular time is not feasible. A survey has been made of office space in that city but the Executive Committee believe that further research and study is necessary in view of the almost prohibitive rental rates which were discovered.

It was suggested that the A.O.T.A. Board and the State Associations write their Congressmen protesting the cut in Federal funds relative to professional personnel and registering disapproval of economy at the expense of the sick.

It is expected that 141 graduates will take the June Registration Examination. The Executive Committee recommends that the 1948 Annual Meeting be held somewhere near New York.

People You Should Know

HOLLAND HUDSON

Master minding the financial affairs of an organization which has come of age as fast as the American Occupational Therapy Association requires sound judgment tempered by experience. AOTA enjoys the services of a Treasurer who fulfills this need.

Holland Hudson began his varied career in San Francisco, Calif. He has the active, evaluative mind which is so typical of successful West Coasters, and the energy to assume and discharge additional responsibilities, the while maintaining a calm approach to the myriad projects which he has under his charge.

His earlier vocations included news reporting, theatre managing, public relations counseling, legal investigation for a federal agency, personnel executive work. Step by step he added to his store of knowledge and experience. From social worker responsibilities, he moved on to vocational counseling and to the direction of rehabilitation hospital services.

This is the background which he has brought to his present post as Director of Rehabilitation Service for the National Tuberculosis Association. His services as Treasurer and a Board Member of the American Occupational Therapy Association, contributed as they are, represent his cooperative interest in all things which contribute to his elected field and especially in occupational therapy.

Mr. Hudson has traveled the United States extensively. He has met and talked with many O.T.'s "on the job." In planning the instruction work on Rehabilitation, he always provides arrangements under which an O.T. may be on the job to talk to the students.

In many cases, students under the jurisdiction of his department have been sent to O.T. schools to take specialized training. Because of

the close association between the two fields, a number of occupational therapists have taken additional instruction and become Rehabilitation Counselors.

Another invaluable contribution to occupational therapy was Mr. Hudson's collaboration with Miss Marjorie Fish, O.T.R., on "Occupational Therapy in the Treatment of the Tuberculosis Patient," an important textbook in the field. He also co-authored with Mrs. Meta Cobb, O.T.R., the story of "Joan Chooses Occupational Therapy," an addition to the Dodd-Mead Career Book series.

MRS. META COBB, O.T.R.

A decade of continuous service sometimes appears to be a subject only for casual mention, but when those ten years are served by an Executive Secretary for an Association which has flowered during her term of office into a mature, intelligent, progressive unit, then that decade bears witness to a contribution which is difficult to measure in mere words.

Meta Cobb is an occupational therapist's occupational therapist. She has been interested in O.T. since she was a 'teenager, and in this capacity served the wounded and disabled veterans of World War I. This correspondent has enjoyed her discussions of occupational therapy in which she pridefully tells of the development of the American Occupational Therapy Association with only casual mention of the vital part which she herself has played in consolidating that development.

She has had a busy, interesting life. Most vivid of her recollections are memories of excursions abroad which she took with her husband in a sort of vagabond way. Four junkets to Europe and two to Africa on unscheduled itineraries gave her a rich background for the Executive Secretaryship of the AOTA which she assumed in 1938.

Jan. 1, 1948, on which date her resignation becomes effective, will mark the completion of ten years during which a multitude of problems have been successfully solved on behalf of a professional association and an office established which can handle a large volume of internal and external organization services.

Two career books on occupational therapy list her as collaborating author. One is "Betty Blake" which she prepared with Edith Stern. The second was co-authored with Mr. Holland Hudson, both selected by Dodd-Mead to add to that publishing company's Career Book Series, a volume entitled "John Chooses Occupational Therapy." Within recent months she had published in *The Independent Woman* an article entitled, "A Field That Knows No Employment Lag."

To whatever new field she may apply herself, Meta Cobb will bring a spirit which we think is best typified by her approach to the problem of finding office space for the AOTA a little more than a year ago. Real estate agents were no help and space in mid-New York was at a premium. So Meta Cobb walked the streets from building to building until finally she encountered a superintendent who gave her information on which she could act.

NEXT NATIONAL O.T. REGISTRATION EXAMINATION

FEBRUARY 27, 1948

A survey of the schools by the Examination Committee shows that there will not be a sufficient number of new candidates for registration to warrant the examination which was scheduled for October 24, 1947.

Did you know that block printing originated in the Orient? It was invented by the Chinese in the latter part of the seventh century. In the fourteenth century block printing was introduced in Europe and was first used in illustrating Bibles.

N. Arola

Did you know that the Fiji Islanders were early discoverers of the use of the stencil in textile printing? The Islanders cut perforations in banana leaves for their stencils, then applied vegetable dyes through these openings on bark cloth.

N. Arola

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ASSOCIATE EDITOR ..... Katharine Rand, O.T.R.
PUBLISHER ..... Shepley Cleaves

Award To Miss Messick

H. Elizabeth Messick
O.T.R.

The Meritorious Civilian Service Emblem and citation have been awarded to Miss H. Elizabeth Messick, O.T.R., for her excellent work as assistant Chief and later as Chief, Occupational Therapy Branch, Physical Medicine Consultants Division, Office of the Surgeon General. The presentation was made by Major-General Norman T. Kirk, Surgeon General, on April 15, 1947.

Miss Messick, who was born on the Eastern Shore of Maryland, graduated from the Occupational Therapy Course at Maryland Institute, and the Post Graduate Course at Walter Reed Hospital in Washington. She served as an occupational therapist at the Walter Reed Hospital from 1933 to 1939, and then left to organize a department of occupational therapy for crippled children for the Bureau of Maternal and Child Welfare of the District of Columbia Health Department. She was later appointed Director of Occupational Therapy for the Department.

In 1944 she transferred to the War Department as Assistant to Mrs. Winifred C. Kahmann, O.T.R. In this position, and later as Chief, she carried with unusual industry and ability a heavy load of responsibility in the development, administration and supervision of the rapidly growing program which introduced occupational therapy personnel into the Army hospitals. Her paper, presenting data regarding this personnel in the wartime program, was read at the Annual Meeting of the American Occupational Therapy Association in Chicago, and this was mentioned with appreciation in the Nomination for the Award.

Convention Highlights

MRS. LUCIE SPENCE MURPHY,
O.T.R., Chairman
Permanent Convention Committee

Psychosomatic Medicine, the main theme of this year's convention, is a subject that is pertinent to all because the aim of every occupational therapist is to provide each individual patient with a maximum opportunity to improve both physically and emotionally. Our profession has recognized the need to treat the "whole patient," and the Thirtieth National Convention with its excellent lectures and demonstrations will be helpful in suggestions for the accomplishment of these objectives.

Lectures on arthritis, medical rehabilitation of paraplegics, physical medicine, pediatrics, and tuberculosis will be included in the program. There will be movies of a program for amputees, and a paper on music therapy. Discussions will concentrate on departmental programs, community problems, and student training programs.

In the lighter vein, there will be the traditional school luncheons, and the banquet, which will be under the able direction of Carolyn Mills, O.T.R. The A.O.T.A. will entertain all visitors at a tea on the patio of the Hotel Del Coronado, famous for its flame colored bougainvillaea vine. A cruise on the bay will also offer a break in the busy days and provide an opportunity for therapists to meet one another.

The Convention rates, under the American plan, cover the cost of both rooms and meals.

PRE-CONVENTION PROGRAM
November 1-2

SATURDAY, NOVEMBER 1

9:00-11:30, 2:00-4:30 Schools and Curriculum Committee

9:00-11:30, 2:00-4:30 Clinical Training Committee

SUNDAY, NOVEMBER 2

9:00-11:30, 2:00-4:30 House of Delegates Meeting

8:00-11:00 Board Meeting

9:00-12:00, 2:00-5:00 V. A. Therapists

TENTATIVE CONVENTION PROGRAM
November 3-4-5

MONDAY, NOVEMBER 3

Morning Session

8:00 Registration

9:30 Business Meeting

Afternoon Session

1:45 Papers: The Emotional Factors of Illness.

Psychiatry in Orthopedics

Psychiatry in Tuberculosis

Psychiatry in General Medicine

4:00 Tea on terrace for AOTA members

Evening Session

8:00-10:00 House of Delegates Meeting

TUESDAY, NOVEMBER 4

Morning Session

9:00-11:30 Papers: Arthritis

Occupational Therapy for Arthritic Conditions

Medical Rehabilitation of Paraplegias

Afternoon Session

2:00-4:30 Round Table Discussions

Body Mechanics for Occupational Therapists

Occupational Therapy in Psychiatric Cases

Departments of Physical Medicine

Occupational Therapy in Tuberculosis Cases

Evening Session

7:00-9:30 Banquet

Board Meeting

WEDNESDAY, NOVEMBER 5

Morning Session

9:00-11:30 Presentation of Papers

A Program for Amputees

A Program for Tuberculosis Patients

Master's Degree Program

Music Therapy
Geriatrics
Noon—1:30 School Luncheons
1:30-3:00 Cruise on San Diego Bay
Afternoon Session
3:00-4:30 Round Table Discussions
Workshops
Juvenile Delinquency
Student Training Program
Cardiac Community Program
THURSDAY, NOVEMBER 6
FRIDAY, NOVEMBER 7
Institute

PERMANENT CONVENTION COMMITTEE

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Jane Myers, O.T.R.
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Mabel Pierce, O.T.R.

THINGS TO DO AND SEE WHILE CONVENTIONEERING

Southern California abounds in things and places to do and see, and therapists who want fullest value from their 1947 Convention excursion will find the Southern California Occupational Therapy Association ready and willing to furnish every possible help to make the trip complete.

Members of the Association will welcome an opportunity to show you any occupational therapy departments operating in hospitals in Los Angeles and vicinity, which include:

Children's Hospitals
Children's Hospital
Children's Hospital Convalescent Home
Los Angeles Crippled Children's Society
General Hospitals
Los Angeles County, Rancho Las Amigas
Psychiatric Hospitals
Camarillo State, Norwalk State
Compton Sanatarium
Orthopedic Hospital
Orthopedic Hospital
Tuberculosis Hospital
Duerte Sanatarium
Veterans' Hospitals
Birmingham Veterans
Sawtelle Veterans' Administration
San Fernando Veterans
Naval Hospitals
Corona, Long Beach, San Diego

After you have visited the therapy departments of your choice, you may wish to tour part or all of Southern California. Following is a partial listing from which you may pick objectives:

Scenic Motor Drives
Angeles Crest Highway to Mt. Wilson, Mulholland Drive, Sunset Boulevard for view of city at night and scenic highway to beach, Wilshire Boulevard to Santa Monica.
Universities and Colleges
University of California at Los Angeles, 405 Hilgard Ave., West Los Angeles; University of Southern California, 3551 University Ave., Los Angeles.
Nearby Attractions
Death Valley (home of Death Valley Scotty), Mission Inn, Palm Springs, Palomar Observatory (home of the world's largest telescope), San Juan Capistrano Mission, Santa Barbara Mission.
Beaches and Resorts
Santa Monica and Laguna Beach on the ocean, Palm Springs and Death Valley in the desert, Lake Arrowhead and Big Bear Lake in the mountains, Santa Catalina Island and its submarine gardens.
Culture and Art
Griffith Park Planetarium, Hollywood Bowl, Huntington Library and Art Gallery, Los Angeles Museum of History, Science and Art, Mount Wilson Observatory.
Other Points of Interest
CBS and NBC Broadcasting Studios, China City, Hollywood, San Fernando Mission, Exposition Park, Forest Lawn Memorial Park.

Next issue will carry suggestions of things to see and do in and around San Francisco and the Bay area. If you want help and suggestions in planning your convention trip itinerary, contact any member of the convention committee. Make your 1947 trip to California one you will long remember.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

33 West 42nd Street, New York 18

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419 South 19th St., Philadelphia 46, Penn.

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Sub-Committee on Reprints and Exhibits
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Handbook Committee
Bertha J. Piper, O.T.R., Chairman

Credentials Committee
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Wisconsin	Ruth Bell, O.T.R.

OFFICIAL REPORT OF BOARD AND COMMITTEE MEETINGS

March 15, 16, 17

Benjamin Franklin Hotel, Philadelphia

PROGRAM

Saturday, March 15

9 a.m. Sub-Committee on Schools and Curriculum
Sub-Committee on Clinical Training (separate meetings—completion of unfinished business.)

2 p.m. Sub-Committee on Schools and Curriculum
Sub-Committee on Clinical Training
Joint Meeting — Presentation of Educational Research Program by Dr. Hyman Brandt

7 p.m. Education Steering Committee
Sub-Committee on Schools and Curriculum
Sub-Committee on Clinical Training
Three separate meetings

Sunday, March 16

9 a.m. Sub-Committee on Schools and Curriculum
Discussion of Topical Outline of all courses in O.T. curriculum
Sub-Committee on Clinical Training
Discussion of Essentials of Clinical Training

2 p m. Continuation of morning sessions

7 p.m. Education Steering Committee

Monday, March 17

10 a.m. Executive Committee of the Board
Open for other committees or group meetings.
Meeting of Psychiatric group requested.

2 p.m. Board of Managers

BOARD OF MANAGEMENT

Agenda

1. Roll Call and Proxies
2. Minutes of previous Meeting (August 11-13, 1946, Chicago)
3. Report of Executive Secretary—Mrs. Meta R. Cobb
4. Report of Treasurer—Mr. Holland Hudson
5. Report of Speaker, House of Delegates—Clare Spackman
6. Report of Educational Field Secretary—Sue Hurt
7. *Report of Chairmen of Standing Committees:*
   Education Steering Committee—Helen Willard
   Registration Committee—Alice Letchworth
   Sub-Committee on Examination—Sue Hurt
   Research Committee—Carlotta Welles
   Legislative Committee—H. Elizabeth Messick
   Public Relations Committee—Mr. Holland Hudson
   Sub-Committee on Finance—Mrs. Guy Misson
   Sub-Committee on A.J.O.T.—Charlotte Bone
   Permanent Conference Committee—Mrs. Lucie S. Murphy
8. *Report of Chairmen of Special Committees:*
   Research Committee on Poliomyelitis—Sue Hurt
   Rules and Procedures Committee—Mrs. John Greene
   Nomination Committee—Ella Fay
9. *New Business*
   1948 Annual Meeting—Time and Place
   Office Lease—1947
10. *Important Letters*

MEETING OF BOARD OF MANAGEMENT

Meeting called to order by President, Mrs. Winifred C. Kahmann, O.T.R., at 2:30 p.m.

ROLL CALL AND PROXIES (present):

Mrs. Winifred Kahmann, President
Marjorie Fish, First Vice-President
Helen Willard, Second Vice-President
Holland Hudson, Treasurer
Mrs. Meta R. Cobb, Executive Secretary
William R. Dunton, Jr., M.D., Honorary Board Member
Beatrice Wade, Board Member
Mrs. John A. Greene, Board Member
Sue Hurt, Board Member & Educational Field Secy.
Virginia Scullin, Board Member
Mabel Davis, Board Member
Elizabeth Wise, Board Member
Margaret Gleave, Board Member
Everett Elwood, Fellow on Board
Catherine Worthingham, Fellow on Board
Clare Spackman, Speaker, House of Delegates
Naida Ackley, Delegate on Board
Mary Booth, Delegate on Board
Bertha Piper, Delegate on Board
Alice Letchworth, Chairman, Registration
Carlotta Welles, Chairman, Research
Mrs. L. S. Murphy, Chairman, Permanent Con. Com.
Charlotte Bone, Editor, A.J.O.T.

MINUTES OF PREVIOUS MEETING

Motion carried to dispense with reading of minutes of previous meeting.

REPORT OF EXECUTIVE SECRETARY

Mrs. Meta R. Cobb reported on the progress in the National Office from September 1, 1946 to March 1, 1947.

All the work resulting from our August Board Meeting and our October Executive Meeting has been taken care of by the President, Executive Secretary and Chairmen of Committees. Copies of these minutes were sent to the Board, House of Delegates and Presidents of State Associations. Many special meetings re Public Relations, Education and Examination Committees were held in the National Office, including a Research Study group of a two-week period, results of which will be given in the Report of our Educational Field Secretary. All Standing and Special Committees have been hard at work.

Our total membership as of March 1 is 2771. After dropping 105 in arrears since 1944, there has been an increase of 258 members since our August, 1946, Annual Meeting.

Placement still keeps up at a steady pace. Since September 1, 1946, we have received 63 applications for positions (mostly from recent graduates) and 51 requests for therapists. It is interesting to note that requests other

than hospitals are increasing daily. Our largest number of requests for placement have been in the orthopedic, mental and general fields. However, requests from Tuberculosis Sanatoria have increased considerably in the last six months.

Our contract with the Phoenix News Bureau was terminated as of January 30, 1947. 20,000 brochures were printed. 2700 sent to our membership; 3250 mailed in bulk to O.T. schools; 5000 direct mailing to art schools, medical schools, physicians, editors of medical health magazines, vocational counsellors, etc. We have 125 letters complementing our brochure and in most instances requesting additional copies.

The office staff have been unusually busy handling work on Service to Committees and compiling the 1947 Yearbook, which we hope will be mailed sometime in April. Two News Letters have been sent out since September, 1946 — together with notices of all types pertaining to meetings, announcing of our new official magazine *"The American Journal of Occupational Therapy,"* Revising AOTA leaflet for free distribution, etc.

The office has received many visitors from foreign lands, including doctors from Brazil, Peru, Chile, Czechoslovakia and France. We have planned visits to hospitals, schools and workshops in and around New York for all these visitors.

Our foreign mail inquiries are increasing and the mailing of books, reprints and general literature for sale and free distribution is still one of the greatest time consuming jobs in the office.

Since the National Office has been planning the itinerary of the Travelling Exhibit, it has been to meetings in Massachusetts, New Jersey, Philadelphia and Texas. It is reserved for the meetings of: National Conference of Social Work, San Francisco, April 13-14; National Council on Rehabilitation, St. Louis, April 29-30; American Medical Association, Atlantic City, June 30.

We are constantly striving to improve our service to members and to speed up the work generally. Our new addressograph machine has helped a great deal in saving payroll time and although the staff have worked overtime during the payment of yearly membership and registration dues there has been no complaint and we all work together in harmony.

Your Secretary has made the usual visits to hospitals by request and attended meetings of Allied Organizations when necessary.

It has been a great pleasure to work with our Educational Field Secretary, Miss Sue Hurt, and her co-operation and help in many ways have been greatly appreciated. She is doing a grand job—we shall hate to see her go.

Again expressing my thanks to the Officers of the Board, Committee Chairmen, membership-at-large and the office staff who have given me their loyal support and cooperation at all times.

Motion carried to accept report with appreciation.

REPORT OF TREASURER

Mr. Holland Hudson reported the financial standing of the Association and explained all items contained in the financial statement.

FINANCIAL STATEMENT

September 1, 1946 through February 28, 1947

Cash on Hand September 1, 1946 (Checking Account)		$15,428.82
INCOME:		
Membership dues	$10,251.50	
Registration fees	8,028.50	
Examination fees	2,474.00	
O.T. & R. Subscriptions	28.75	
A.J.O.T. "	199.25	
Sales:		
Directory Sales	57.87	
Directory Advertising	21.25	
O.T. Insignia	635.17	
O.T. Pins	160.00	
Reprints	486.39	
Volunteer Course	38.00	22,380.68
		37,809.50
EXPENDITURES:		
Administration	$ 585.08	
Co-operation with other Agencies	31.89	
Educational Publicity	701.27	
Purchases:		
O.T. Insignia	389.12	
O.T. Pins	198.00	
Reprints	289.38	
Placement Service	882.23	
Publication Expense	6,780.76	
Membership	999.35	
Registration	2,595.83	
Examination	3,470.16	
Service for Committees	2,513.85	
General Service & Office Expense	3,561.83	
Public Relations Fund	2,500.00	25,498.75
		12,310.75
Deduction for S.S. and Withholding Taxes to be offset by re-imbursement to U. S. Government		35.19
		12,275.56
Less: 6th payment on Scholarship—$250 monthly. Received $2500 in bonds from Baruch Fellowship Fund entered in Investment a/c		1,500.00
Balance in General Fund February 28, 1947		$10,775.56
Accounts Payable		$ 892.98

REPORT OF HOUSE OF DELEGATES

Miss Clare Spackman, Speaker, reported an increasing number of inquiries relative to forming new state associations. The following are the results of House of Delegates' survey on moving National Office to the Midwest: Of the twenty-five state associations requested to report: Thirteen states definitely desire the office moved. Two states are not strongly against the move. One state is for the move with provision for a branch office in New York. Two states are definitely against the move. One state wants careful consideration given to the matter. Five states did not reply. Southern California did not want their feeling of moving the office to influence the change favoring any plan most advantageous for the entire association.

The Executive Committee recommends an increase in membership and re-registration dues as a fund-raising device for anticipated professional activities of the Association. The Board authorized a letter be sent to the delegate of each state association presenting the idea of increased dues and stressing the fact that this is in accordance with policies of allied professional associations. This recommendation will be taken to the Board for favorable approval at the next Annual Meeting in October. Motion carried to use the facilities of A.J.O.T. to circularize the membership regarding increased dues.

Motion carried empowering the Executive Committee to act in accordance with the majority of House of Delegates on moving the National Office at such time as a careful study of location in the Middle West can be determined and as soon as necessary preparations can be arranged.

The Executive Committee recommends for the Board's approval the appointment of Wilma West, O.T.R., as Educational Field Secretary to succeed Sue Hurt. Motion unanimously carried to approve this recommendation and Miss West will be contacted in the hope she will accept this appointment, to become effective September 1, 1947.

REPORT OF EDUCATIONAL FIELD SECRETARY

Miss Sue Hurt reported as follows:

REPORT OF THE SUB-COMMITTEE ON EXAMINATION

There have been four meetings of the Sub-Committee on Examination as follows:

1. August 14 in Chicago—to decide questions regarding the October '46 examination.

2. September 28 in Philadelphia—to review and revise the examination which had been constructed in the Education Office to be given October '46.

Recommendation was made at this time to the Executive Committee of the Board that the assistance of Dr. Hyman Brandt, test expert, be secured before attempting another examination.

3. November 2 at the National Office—for discussion of the Educational Research Program and for initiation of plans for procedure.

4. February 1 at the National Office—to review and revise the February '47 examination which had been constructed by a special research group.

Summary of Decisions and Recommendations

1. *Evaluation of the results of the June '46 Examination.*

2. *Schedule of examinations to be given in 1946-47*—It was recommended that a survey be made of all schools of occupational therapy for the expected number of applicants and the dates of eligibility throughout this period. On the basis of the survey, decision was made to continue the existing schedule, the examination to be given on the fourth Friday of every fourth month, falling in February, June and October.

3. *Place of examination*—It has been decided that the examination shall be taken in schools of occupational therapy by all applicants within a radius of 200 miles of such schools. That others may have the examination administered in accredited institutions of higher learning acceptable to the school of graduation. Exceptions to this only on committee action.

4. *Method of constructing the examination*—It was recommended that the October '46 examination be constructed in the Education Office with review and revision by the Sub-Committee on Examination. That immediately thereafter the advice and guidance of a test expert be sought in developing a more valid procedure and that experts in each field work under his direction. This recommendation was taken to the Executive Committee of the Board and received its authorization.

5. *Dual billing for examination and registration*—In accordance with the recommendation of the Registration Committee August '46, application for examination and for registration were sent out together. At the suggestion of the Education Office, membership applications were included, with what was considered to be an adequate explanation. The procedure proved confusing both to the applicants and to the National Office. The Sub-Committee on Examination therefore recommended that this be discontinued for the February '47 examination and that it be legally discontinued at the next opportunity. This is being recommended by the Chairman of the Registration Committee.

6. *Type of examination*—Under the guidance of Dr. Brandt, it was decided to use for February '47 and thereafter, an all-objective examination in the multiple choice form, the examination to consist of 300 items.

7. *Procedure for administration*—A revision of procedure was approved to conform to the change in type of examination. It was decided that the examination should be administered in two sections, 150 items each, with two-and-one-half hours working time allotted to each section.

8. *Release of examination results*—Decision was made to give each school the numerical rating of all its graduates for current and past examinations with the

request that the examinee be given the rating in terms of "passed" or "failed."

9. Evaluation of clinical training toward registration—Decision was made to use the same 5, 10, 15% evaluation which had been used previously, for the October '46 examination, and to seek guidance from Dr. Brandt in the evaluation for future examinations.

Approval was given for the evaluation of all clinical training reports in the Education Office for the February '47 examination and for those to follow.

The Education Office was instructed to request all schools to employ the forms developed in 1945 for experimental use by the Sub-Committee on Clinical Training.

Decision was made to develop a similar form for evaluation of work experience and that this form be used in addition to clinical training reports for employed applicants for registration.

Development of a more valid student clinical rating form is a part of the plan for the development of a more valid registration procedure.

It is recommended at this time that the evaluation of clinical training achievement be given a value of 25% of the total evaluation of an applicant for registration, with the possibility of an even higher value when the procedure for the evaluation of clinical training achievement shall have become more valid. Decision regarding this is requested at this time in order that evaluation of current applicants may be completed. Motion carried to accept 20% evaluation for clinical training until there is standardization of clinical training at which time it will be raised to 33-1/3%.

Statistics for past examinations

June '45		*October '45*	
Passed	149	Passed	237 (5 retakes)
Failed	20	Failed	30 (1 retake)
	169		267

March '46		*June '46*	
Passed	267 (9 retakes)	Passed	222 (19 retakes)
Failed	22 (3 retakes)	Failed	26 (5 retakes)
	289		248

October '46		*February '47*	
Passed	73 (10 retakes)	Total taking exam	161
Failed	9 (3 retakes)	Retakes	13
	82		

Total number of persons who have taken the examination to date	1149
Total number of persons who have failed and retaken the exam	67
Total individual examinations given	1216
Total failures	107

Report on the Registration Examination and the Educational Research Program

October '46 Examination—In accordance with the recommendation of the Sub-Committee on Examination, this examination was constructed in the Education Office for subsequent review and revision by the aforesaid committee. Revision was made also of procedure and forms for administration of the examination.

Survey for Examination Dates—In accordance with the recommendation of the Sub-Committee on Examination, the schools were surveyed for numbers and dates of eligibility for examination for all graduates through '47. It was decided to continue the examination schedule as before and the following dates were announced for 1947—February 28, June 27 and October 24.

October 17 '46 Educational Research Program Recommended—At a meeting of the Executive Committee of the Board, recommendation was made for the initiation of an educational research program leading to a more valid procedure for registration, to be carried out with the cooperation of the Education Committee and Sub-Committees and the Sub-Committee on Examination and under the guidance of Dr. Hyman Brandt, Educational Psychologist and test expert, in the capacity of Educational Research Consultant. It was further recommended that an additional full-time secretary, qualified for statistical research, be employed on this program and that occupational therapy specialists in all fields covered by the occupational therapy curriculum be subsidized for a two-weeks period of intensive study and examination construction. This was authorized by the Executive Committee.

Materials Requested as Basis for Study—The schools were requested to send outlines of all courses in the occupational therapy curriculum. The clinical training centers were requested to send outlines of programs of clinical training.

December 27-January 11 Special Research Group—Eighteen occupational therapy specialists covering every aspect of the occupational therapy curriculum met in New York for an intensive period of study and examination construction, basing their work on the materials collected as given above. The goal for this group was as follows:

Topical Outlines—for every course in the occupational therapy curriculum. These have been completed and submitted to the Sub-Committee on Schools and Curriculum and to its Sub-Committee on Curriculum Guide.

Factual Outlines—for all occupational therapy theory courses and all skills courses. These are still in preparation to be turned over to the Sub-Committee on Curriculum Guide when complete.

February '47 Examination—consisting of 300 multiple choice items. This has been completed, the examination given and an analysis of results prepared for presentation at the current education

meetings.

Examination Pool—or file of 1500 items—this is still under construction and will be submitted to the Sub-Committee on Examination when completed.

February 1 Meeting of Sub-Committee on Examination—This meeting was held in the National Office for review and revision of the examination constructed by the special research group to be given February '47. The procedure for administration has been revised in accordance with the change in type of examination.

Essentials of a Clinical Training Program—ultimate basis for accrediting.

November 22—Meeting with Directors of Clinical Training, Philadelphia School of O.T. At the November 16 meeting in the National Office it was found that the Philadelphia School of Occupational Therapy had scheduled a meeting for its clinical training directors for the following week. It was agreed that this meeting be turned over to the Educational Office for launching of this program. A preliminary statement of the Essentials of a Clinical Training Program was begun at this meeting and completed at a subsequent meeting of the same group. Much of the work on the original statement was done by Miss Ackley and Miss Hubner of Trenton.

Request for Review and Revision of Essentials—This preliminary statement was sent to all schools and to all clinical training centers throughout the country with request for revision in meetings of school groups wherever possible, or individually.

January 17—Meeting with Directors of Clinical Training Centers of Columbia—This meeting was held for discussion and revision of Essentials.

February 8—Meeting with Directors of Clinical Training for Boston School of O.T.—This meeting was held for discussion and revision of Essentials.

February 22—Meeting Members of the Sub-Committee on Clinical Training—This meeting was held in the National Office for revision of the original statement of Essentials on the basis of comments and reworking throughout the country.

This revision has been turned over to the Sub-Committee on Clinical Training.

American Medical Association Survey—The survey forms sent annually by the American Medical Association to schools of occupational therapy were revised and expanded in the Education Office and approved by the heads of committees concerned. These were distributed to the schools by the A.M.A. The results of this completed survey have been particularly collated for presentation at the current Education meetings. These are to be completed and sent the schools.

Uniform Clinical Training Reports—These have been prepared in the Education Office for sale to schools which have placed their orders. Additional forms are available if needed by other schools. This is in response to the request of the Sub-Committee on Examination that uniform reports be used for purposes of evaluation of clinical training toward registration. The forms to be used were developed by the Sub-Committee on Clinical Training in '45 for experimental use by all schools.

Work Report Form—This has been developed upon recommendation of the Sub-Committee on Examination for an additional means of evaluation of an employed applicant for registration. This form is based on the clinical training report form.

Skills Survey—Another phase of the educational research program not yet begun, but which has been considered and approved in committee, is a Skills Survey to be sent to every occupational therapy department in the country in order to discover which skills and which techniques within those skills are currently in use, so that skills courses may prepare students adequately for present-day needs and trends. The printing of this survey will cost $300.00. This project cannot be undertaken without specific authorization.

Charts showing present and envisioned development of Educational Research Program—Attention is called to the charts developed by Dr. Brandt to interpret the Educational Research Program. The present program is given in one group and the program envisioned for the future is given in another group. In a careful study of these charts it becomes increasingly evident that we have just begun.

Other Phases of the Work of the Education Office

Handbook of Occupational Therapy—A revision has been made up of the Handbook inaugurated in 1946 by the House of Delegates and the Education Office. The work on the original issue having been done mainly by Miss Bertha Piper and Miss Henrietta McNary. The revised and expanded Handbook is herewith presented. Two thousand copies have been printed to be sold at $1.00 each. An announcement "Flyer" with order blank will be sent with the next Newsletter.

Legalization—The major report of the Legislative Committee will be given by Elizabeth Messick, Chairman. However, since the Education Office shares the responsibility for this phase of our program, a brief report will be included here.

In September '46 the Educational Field Secretary conferred with Miss Elson and Miss White of the American Physiotherapy Association in regard to the legislative problems of our two organizations. Following this, a request from Miss Elson was presented to the Executive Committee of the Board asking for cooperation with the American Physiotherapy Association for immediate action toward legalization in two states. The Committee authorized action and appropriated $1,000.00 for legal advice as necessary.

Two subsequent meetings have been held, one in Washington and one in Maryland in regard to joint

occupational therapy and physical therapy action in Maryland. This will be further reported by Miss Messick.

Recommendations

In summary it is recommended that:

1. Additional appropriation of salary for the Educational Research Consultant be made for completion of the present program and the June Examination. Moved and seconded that the services of Dr. Hyman Brandt, Research Consultant, after completion of his remaining 100 hours, be continued and that an additional payment be appropriated to complete the program of evaluating the February 1947 examination and the clinical training rating of the examinees; to assist the sub-committee on Clinical Training in the construction of a key for increased uniformity in the use of the present clinical training report form, for construction and evaluation of the June examination and evaluation of clinical training rating for examinees and for clarification and compilation of information included on our current school survey.

2. The salary of the research secretary be increased to equal other personnel with comparable training requirements in order to ...ain a person qualified to do the work required. Motion carried increasing the salary for a statistical secretary on Examination Research in proportion to the personnel in the office with similar qualifications.

3. Careful consideration be given the proposals for future projects in the Educational Research Program, and to their presentation to a foundation with request for subsidy.

At the current Education and Board meetings a gift of $1,000.00 has been made by an occupational therapist who insists that she remain anonymous. The money was given for continuation of the Educational Research Program.

Appreciation extended to Miss Hurt for her untiring efforts.

REPORT OF EDUCATION STEERING COMMITTEE

Miss Helen Willard, Chairman, reported the following:

At the last meeting of the Education Steering Committee held in Chicago, August 10-15, 1946, certain recommendations were made to be sent to the Council on Medical Education and Hospitals of the American Medical Association. Action has been taken on these recommendations as follows:

1. The council has concurred in the recommendation that the official inspection of new schools of occupational therapy be made as soon as possible after the first group of students has completed a minimum of six months of the required clinical training. Dr. Westmoreland is leaving the Council and it has, therefore, been suggested that the visits which should be made within the next few months should be undertaken by a representative of the Education Committee of the American Occupational Therapy Association. The American Medical Association will bear the cost of the trips. Plans are being made for a qualified therapist to visit the College of St. Catherine, St. Paul, Minnesota; the College of Puget Sound, Tacoma, Washington; Texas State College for Women, Denton, Texas; and the University of Wisconsin, Madison, Wisconsin, within the year.

2. The Council has approved the principle that the therapist serving in the capacity of Director or Coordinator of a course, should have a voice in the selection of incoming students. It is hoped that a statement to this effect will be incorporated in the next publication of "Essentials of an Acceptable School of Occupational Therapy."

3. The recommendation was made to the Council that a letter be sent to all schools, both approved and as yet unapproved, that no student is to be sent to an affiliating hospital before having had the theoretical and technical work applicable to that particular field. To our knowledge no action has been taken on this recommendation.

4. The Council concurred in the recommendation that a statement go from the A.M.A. to the Registration Committee of the A.O.T.A. relative to the approval of a given school in order that consideration may be given to the first graduates of that school, thereby enabling them to qualify for the Registration Examination before the school has acquired final and official approval. Such a statement of approval was issued in behalf of the College of Puget Sound, the College of St. Catherine and Texas State College for Women.

A number of recommendations made by the Sub-Committee on Schools and Curriculum have been made the subjects of further study as follows:

1. The Curriculum Guide started by Miss McNary is being further developed under the Office of the Educational Field Secretary with Dr. Brandt as consultant. Miss McNary is Chairman of a committee for further study of this matter.

2. Further study is being given to the problems of acceptance of students with physical disabilities in an effort to establish some tangible standard.

3. There is to be further analysis of the "advanced standing" courses in order to standardize them. The questionnaire recently completed for the Office of the Educational Field Secretary should yield valuable material for this study.

4. The question of the logical relation between instructor and student group has been referred for further study.

Reported that Dr. Westmoreland has resigned from the Council on Medical Education and Hospitals of the American Medical Association. The Board expressed their regret on Dr. Westmoreland's resignation.

Miss Henrietta McNary, Co-Chairman, Education Steering Committee, as representative of the American

Occupational Therapy Association, will visit in the near future, College of St. Catherine, St. Paul, Minnesota; College of Puget Sound, Tacoma, Washington; Texas State College for Women, Denton, Texas; and University of Wisconsin, Madison, Wisconsin. The American Medical Association will bear cost of the inspection trips. Report of Education Steering Committee accepted with thanks.

REPORT OF REGISTRATION COMMITTEE

Miss Alice Letchworth, Chairman, reported the total of 2144 registered occupational therapists in good standing for 1947, approximately 1500 of which are actively engaged in O.T. work.

The Registration Committee recommended to the Board for approval that Membership no longer be a requirement for Registration in the A.O.T.A. Motion carried approving this recommendation.

Registration Committee recommended reverting back to previous procedure of separate billing for examination and registration fees. Motion carried authorizing office to call for examination fee first, and registration fee at time the grades are sent to the O.T. schools.

The Directory has gone to print and we await delivery.

This report accepted with appreciation.

REPORT OF COMMITTEE FOR SCIENTIFIC STUDY AND RESEARCH

Miss Carlotta Welles, newly appointed Chairman gave the following detailed outline of the work of this recently reorganized committee:

I. *Program as Planned*

At the time of the resignation of the previous chairman of this committee, several projects were considered completed except for publications. See report as submitted to this board in August, 1946, by Miss Lucy Morse, the retiring chairman. Therefore, a completely new program has been conceived, which nevertheless, incorporates many of the recommendations made in above report.

The present plan of action may be divided in three parts. First emphasis will be placed on the development of research-mindedness and critical thinking on the part of each individual therapist. In the A.J.O.T. where this committee has a section in each issue, the individual will be invited to evaluate her own program in terms of: "what am I doing which might be of value to others?"; "what specific projects if undertaken by another group would be helpful to me?"; and finally, "what do I need most to study?" Special projects will be so organized that *many* therapists can and will be urged to contribute. In order to better serve the field as a whole, every effort will be made to have the projects of this committee represent the thoughts and problems of a maximum number of therapists.

The second part of the program is concerned with specific research projects which will be guided by one of the two sub-committees: Neuro-psychiatry or General and Physical function. Careful attention will be given to the selection of projects for study which are of sufficient value to justify the time, money, and effort spent. It it suggested that it is not worthwhile to develop material which can be easily secured from books. Furthermore, the research value of individually prepared papers and surveys is seriously questioned unless done according to established methods and principles of research. It is suggested that the preparation according to a prepared outline of an adequate number of case studies would prove interesting and would serve as valid basis for subsequent study and generalization. These could be done in one or more fields as is deemed possible and desirable. Other special projects not part of this plan will be undertaken as indicated.

The third and final part of the program did involve graduate study for the graduate therapist. After considerable discussion in the committees meeting at this time, this project has been transferred to the sub-committee on schools and curriculum.

II. *Development of Projects*

The sub-committee on General and Physical Function, in cooperation with the planning committee of World War II occupational therapists, is preparing a manual of adapted equipment. It is hoped that this manual will be as complete as possible, including not only the familiar functional equipment, but material and adapted games used in general, children's, tuberculosis, homebound, and all other fields of specialization. Sample drawings and material will be published in A.J.O.T. from time to time.

The sub-committee on Neuropsychiatry is preparing material on methods of research in Neuropsychiatry and how to use research material prepared by allied groups and professions. This will be presented as available, giving references to related material. An outline is being prepared covering the purpose, and preparation of case studies. These should be done with medical guidance and will include, whenever possible, a portion to be prepared by the patient himself.

Following this outline, occupational therapists in this field will be invited to submit case studies on which subsequent research can be done.

III. *Problems*

Two problems are presented at this time:

1. appropriate funds to publish manual and develop research on case studies.
2. medical guidance or consultant service for the work of this committee.

The Board expressed appreciation to Miss Welles for her informative report.

REPORT OF SUB-COMMITTEE ON A.J.O.T.

Miss Charlotte Bone, Chairman, reported the following:

At the Executive Meeting held last October at New York, your editor accepted the responsibility of preparing and assembling the content of a new publication to be the official journal of A.O.T.A.

Plans for the magazine were immediately initiated and during the latter part of December, a contract was signed with Mr. Cleaves to act as the publisher. In return for a salary of $2500 a year, he agreed to organize a publishing office, to style the new publication typographically, to supervise production, sell advertising and exert whatever promotional measures might add to space revenue and circulation. Six issues comprising a 400-page volume will be produced on a bimonthly schedule during 1947.

On January 1, 1947, the Association withdrew all support and sanction from O.T.&R., published by Williams & Wilkins, and soon after, announced that its own publication would be The American Journal of Occupational Therapy. We are happy indeed that Mr. Dunton still remains associated with the official organ of our association as Editorial Advisor.

A.J.O.T.'s first issue finally surmounted all difficulties and is now distributed. One of our first and immediate problems is that we had much too much material available. With continuation of the cooperation already evidenced by each of the division editors, A.J.O.T. will continue to have a superabundance of material until the day when it becomes at least a monthly publication.

The *Governing Board* will consist of the Editor, the Assistant Editor, and the Managing Editor. *An Advisory Committee*, composed of specialists in related professions will insure that we present accurate interpretations and statements regarding their professions. *Contributing Editors* will provide at least one article or editorial a year and *Reporters* will convey information from the state and regional associations. The *Division Editors* will be the most instrumental factors in having a good scientific magazine because as specialists they will represent their fields to the reader.

This report accepted with appreciation.

REPORT OF PERMANENT CONFERENCE COMMITTEE

Mrs. Lucie Murphy, Chairman, reported details of program and plans for the 1947 Annual Convention in San Diego. More details on convention program and activities will appear in an early issue of A.J.O.T. and in the May issue of the Newsletter.

Motion made and seconded the decision as to time and place of 1948 Annual Meeting be referred to the Executive Committee, urging the members to make specific choice between New York City in October or Lake Mackinaw, Michigan, in July. Report accepted with thanks.

REPORT OF RULES AND PROCEDURE COMMITTEE

Mrs. John Greene, Chairman, distributed a General Organization Chart for the A.O.T.A., purpose of which is to get a clear picture of the function of office administration and association committees. In this proposed plan there would be an Administrative Director in the National Office responsible to the Board of Managers. Under the Administrative Director would be Educational Field Secretary, responsible for Educational and Research programs. The President announced to the Board at this time the resignation of Mrs. Meta Cobb as Executive Secretary.

The Board moved and seconded unanimous approval of the appointment of Mrs. Winifred Kahmann as Administrative Director if conditions permit.

Moved and seconded with help of the Treasurer a financial study be made relative to the cost of operating National Office at present, the cost of operation in the interim and the cost of operation of National Office in Midwest with Mrs. Kahmann as Administrative Director. This study to be referred to Executive Committee for final decision.

Meeting adjourned at 7:00 P.M.

MEETING OF EXECUTIVE COMMITTEE

The meeting was called to order at 10 a.m. by President Mrs. Winifred Kahmann. Other members present were: Marjorie Fish, Helen Willard, Clare Spackman, Sue Hurt, Beatrice Wade, Elizabeth Wise and Mr. Holland Hudson.

Motion carried to accept the minutes of previous meeting as distributed.

Miss Marion Clark, Chairman of the Travelling Exhibit, sent a letter of resignation. The Committee expressed their appreciation of Miss Clark's work in connection with the Travelling Exhibit and planning its itinerary over a period of many years. Appointment of a new chairman is held in abeyance until the exhibit may be revised or renewed. Miss Clare Spackman, Speaker, House of Delegates, appointed chairman of Constitution Committee to amend the Constitution permitting vote by mail, thereby giving the entire membership voice in elections and not just limiting voting to those members present at an annual meeting.

REPORT OF HOUSE OF DELEGATES

Miss Clare Spackman, Speaker, reported the following results of the House of Delegates Survey on moving the National Office to the mid-west: Of the twenty-five state associations requested to report: thirteen states definitely desire the office moved. Two states are not strongly against the move. One state wants careful consideration of the matter. One state is for the move with provision for a branch office in New York. Two are definitely against the move. Five states did not reply. Southern California did not want their feeling of moving the office to influence the change, but favoring any plan most advantageous for the entire Association.

REPORT OF TREASURER

Mr. Hudson read his financial statement and explained all items contained therein. In view of future financial needs of the association the Executive Committee recommended that dual billing from the National Office of these two fees be established for 1948.

Originally this was a recommendation of the House of Delegates, therefore, it was suggested communicating with delegates of each state association to present the idea of increasing dues to their group. Their reaction, together with the above recommendation, will be brought to the Board at the Annual Meeting for favorable consideration.

The dual billing procedure would necessitate the National Office collecting all national membership dues directly and the state association being responsible for their own state dues only. It is felt that this procedure would eliminate a great deal of confusion on behalf of the members and treasurers of state association. The National Office would check with the state associations in order to assure the maintenance of membership in both the national and state associations.

RE-ORGANIZATION OF NATIONAL OFFICE

Moved and seconded the Executive Committee recommend to Board the appointment of Wilma West, O.T.R., to the Office of Educational Field Secretary.

Moved and seconded that the services of Dr. Hyman Brandt, Research Consultant, after completion of his remaining 100 hours, be continued and that an additional payment be appropriated to complete the program of evaluating the February, 1947, examination and the clinical training rating of the examinees; to assist the sub-committee on Clinical Training in the construction of a key for increased uniformity in the use of the present clinical training report form; for construction and evaluation of the June examination and evaluation of clinical training rating for examinees; and for clarification and completion of information included on our current school survey.

Motion carried increasing the salary for a statistical secretary on Examination Research in proportion to the personnel in the office with similar qualifications.

Motion carried recommending the Board give careful consideration relative to moving National Office to mid-west and planning re-organization of National Office insuring efficient administration of association activities.

Motion made and seconded that the Syllabus on Physical Injuries be made available to registrants of the 1946 Institute.

Meeting adjourned 11:45 a.m.

NOTICE OF THE ONE YEAR LIMIT

At the March Board Meeting the ruling was made that a Therapist applying for Registration must do so within a year after having passed the Registration Examination.

DELEGATES DIVISION

Miss Bertha J. Piper, O.T.R., Editor

DISTRICT OF COLUMBIA

Violet Corliss, O.T.R., Delegate Reporter

The D.C.O.T.A. held seven meetings during the past year. The programs have been planned to inform the members of accomplishments in O.T. and allied professions and organizations.

The meeting held in September, 1946, took place in the occupational therapy shop at Walter Reed Hospital, and was devoted largely to reports on the A.O.T.A. convention at Chicago. The delegate from the D.C.O.T.A. reported on meetings of the House of Delegates and the general business meeting. Other members who had attended the convention reviewed salient points from various lectures and discussions.

At the National Naval Medical Center, in October, the Association was privileged to hear a splendid presentation of topics by Navy personnel. Commander J. S. Gruggel and Captain G. W. Raines spoke on "Rehabilitation," Lt. Comdr. H. R. C. Chalmers on "Aid of Occupational Therapy in Initiating Patients," Lt. Lois Brownell on "The Occupational Therapy Program in the Navy" and Ens. L. Jean Kretsinger on "The Navy Training Program." The November meeting was held at the Crippled Children's Society, Mrs. Jewell Gaffney, R.N., the Executive Secretary, relating the Development and Activities of the Society.

A lecture, "The Part Played by Activity in Learning New Emotional Patterns," was given in January, 1947, by Mr. Charles N. Cofer, Ph.D., Associate Professor of Psychology at George Washington University. This was followed by a round-table discussion on "Attitudes Toward O.T. Attendance." The advantages of the various methods of securing patient participation in a program were presented by several members of the association and by Miss Garland Lewis, R.N., a psychiatric nurse. The methods described were "Patients' Initiative, Invitation, Routine, Persuasion, Insistence, and Force."

The February program was based on Occupational Therapy and Rehabilitation in a Convalescent Tuberculosis Hospital. Miss Violet Corliss, O.T.R., described the program at Upshur Street Hospital. Mr. James E. Gardner talked on "Initial Factors in Vocational Coun-

seling." Dr. David Leibovici, whose topic was "Evaluation of a Rehabilitation Program," brought out the many factors which must be taken into consideration in making scientific evaluation.

Mrs. Desmond Foster and Miss Katherine Smithies, tutors at the Remedial Education Center, were the March speakers. They explained some of their methods of teaching the slow reader and persons with other learning difficulties. Two Army films were also shown. These covered the making of appliances according to individual measurements and the treatment of the patient until he has passed a test in the use of his prosthesis.

The recreation room at the Crippled Children's Society was offered to us as a regular meeting place and the last four meetings have been held there. The association has voted to accept the offer as the Society is centrally located. This will make it possible for more members to attend all meetings.

The constitution of the D.C.O.T.A. was revised during the past year to conform to the constitution of the A.O.T.A. A major change in the by-laws was the inclusion of a complimentary membership clause. Active members of other state or regional associations, temporarily residing in the area, will be extended reciprocal membership as complimentary members (without paying additional dues for a period not to exceed six months. Active members of other state or regional associations permanently transferring to this area will be extended reciprocal membership upon request for the balance of the year or for a period not to exceed four months. Both may be voting members but may not hold office.

There has been a large influx of occupational therapists in this area in recent months, and we are endeavoring to assimilate them and make use of their services in the association.

Two new departments of occupational therapy have been opened in the past year:

Good will Industries, Inc.

Freedman's Hospital Annex (tuberculosis)

A group of five occupational therapists are attending a seminar in occupational therapy under the guidance of Dr. Alfred Stanton of the Washington School of Psychiatry. The aim of the group is to determine by scientific method the contribution of occupational therapy to patients' improvement and recovery, and how it does so.

Officers of the D.C.O.T.A. are:

President, Miss Elizabeth P. Ridgway, Chestnut Lodge, Rockville, Md.

Vice-President, Miss Caroline Norfleet, Mt. Alto Veterans' Hospital, 2650 Wisconsin Avenue, Washington, D. C.

Secretary, Miss Leta Wight, Washington Sanatorium, Takoma Park, Washington, D. C.

Treasurer, Miss Violet H. Corliss, Upshur Street, Hospital, Washington 11, D. C.

Delegate, Miss Violet H. Corliss, Upshur Street Hospital, Washington 11, D. C.

SOUTHERN CALIFORNIA

Elsie Geertz, O.T.R., Delegate-Reporter

The S.C.O.T.A. has met three times within the past six months. Two meetings have been held at the new Curative Workshop in Los Angeles, while the last one took place at the Brentwood Veterans Neuro-psychiatric Hospital in West Los Angeles. Programs at these meetings included talks by orthopedists and psychiatrists. The business transacted at these meetings had to do mainly with the selection of a location for the American Occupational Therapy convention and the appointment of working committees to further its success. The Hotel del Coronado, Coronado, California, was chosen because it was the only hotel large enough to accommodate the O.T. assembly in late October.

A joint committee of the Welfare Council and the Los Angeles County Tuberculosis and Health Association is working out plans for Home Service O.T., particularly for cardiac children. Three occupational therapists from the S.C.O.T.A. are on the committee.

New salary schedules and requirements are being set up by the State Civil Service Commission particularly for work with the cerebral palsy program.

The California Personnel Board has recently reclassified its occupational therapy positions in state institutions into two classes: Grade One and Grade Two. Grade One salary steps range from $210 to $250 per month, and Grade Two from $270 to $310. The Personnel Board contemplates a Grade Three position with a proportionate salary range.

TEXAS

Lenore Brannon, O.T.R., Delegate-Reporter

Publicity concerning occupational therapy in Texas has grown during the past year. The T.O.T.A. bulletin has been mailed to all members and member hospitals. The Association has been asked to submit, for publication in the Journal of the Texas Hospital Association, any questionnaires, programs, or articles it may desire to present to the medical profession. Miss Lenore Brannon, O.T.R., President of T.O.T.A., is a member of the Editorial Advisory Committee of "TEXAS HOSPITALS," and had an article published in the Journal.

Speeches have been made by various members throughout the state, to the Women's Club, Fort Worth; Grey Ladies Volunteer Group, A.R.C., Fort Worth; to students at Texas Christian University, Fort Worth; and to classes at the Hockaday Jr. College, Dallas. A local radio program, "Passing in Review," carried a talk by Mrs. William Caldwell, from the Methodist Hospital, Houston.

The twelfth annual convention of the T.O.T.A. met in Houston with the Texas Hospital Association and the

four allied groups at the Rice Hotel, March 27-29, 1947. Forty members were present representing Psychiatric, Veterans', Naval, Children's, Tuberculosis, Army, Public Health, and State Hospitals from Texas and Louisiana.

The business meeting at the afternoon session on Thursday, the 27th, included a roll call with a new craft idea, and introduction of new members. Following the business meeting a dinner was held in the Hunt Room at which time the speakers were Miss Mary Britton, O.T.R., and Mrs. Claude McDowell Myres. Miss Britton has come to Texas as the consultant for Branch number 10 of the Veteran's Administration. Mrs. Myres is director of the Sheltered Workshop of the Texas Society for Crippled Children. She spoke on her experiences as the Director of the first group Corps of Reconstruction Aides to France in World War I.

The program on Friday was as follows:

"Correlation of Physical Therapy and Occupational Therapy in Orthopedics" — Denman C. Hutcherson, M.D., Consultant, Jefferson Davis Hospital, Santa Fe, and Houston.

"Occupational Therapy as a Basis for a Rehabilitation Program"—David Wade, M.D., Consultant, State Board of Vocational Rehabilitation and Education, Austin.

"The Psychiatrist"—Ben L. Boynton, M.D., Director, Physical Medicine, Shannon Memorial Hospital, San Angelo; Branch Section Chief, Physical Medicine, Veterans Administration, Dallas; Consultant, Physical Medicine to Surgeon General, Fourth Army Area, Fort Sam Houston, Texas.

"The Problem of Occupational Therapy in the United States Navy"—Lt. Worth M. Gross, M.C., U.S.N., U. S. Naval Hospital, Houston.

"Goodwill Industries in Texas"—Mr. C. E. Koerbls, Houston.

"Trends of Medical Rehabilitation" — George A. Walker, Acting Chief, Medical Rehabilitation, Branch number 10, Veterans Administration, Dallas.

"Habit Training Occupational Therapy"—Film made at St. Elizabeth's Hospital, Washington, D. C.

Saturday morning the groups visited the United States Naval Hospital and toured the azalea gardens in the residential district before the concluding luncheon.

An exhibit at the T.O.T.A. Convention was supervised by Miss Cornelia Ann Watson, O.T.R., Director of Occupational Therapy at Texas Scottish Rite Hospital for Crippled Children, Dallas—with assistance from students at the School of Occupational Therapy, Texas State College for Women, Denton.

Occupational Therapy Department in Miniature — figures of patients and therapists modelled of papier-mache—equipment constructed of wood, metal, string —craft materials—showing patients at work at all the crafts used as "tools" in the medical rehabilitation program. Exhibit of finished articles of craft projects. Free literature on occupational therapy for distribution. This exhibit was highly praised by members of the Texas Hospital Association's medical profession, as presenting occupational therapy in a manner which everyone could understand.

The T.O.T.A. is accepting members from Arkansas, Louisiana, Mississippi and New Mexico, as occupational therapists in those states requested permission to join the Texas Association until such time as their own states have separate organizations. Dues should be sent to Miss Pauline Hogshead, O.T.R., Secretary-Treasurer, c/o Veterans Administration Hospital, Waco, Texas.

The T.O.T.A. has sixty-one members, and twenty-nine member hospitals.

MASSACHUSETTS

Jan Merrill, O.T.R., Delegate-Reporter

During the year 1946-1947, the M.A.O.T. has held three meetings of special interest to its membership. On November 15, 1946, a Twenty-Fifth Birthday Celebration of the Association was held at the Beaconsfield Hotel. After the business meeting Mrs. Ruth Whitney, dressed as a Reconstruction Aide of 25 years ago, cut a large birthday cake and spoke on the Growth and Organization of this State Association. Miss Marjorie Fish, O.T.R., of Columbia University, spoke on the Importance of Correlation between National and State Associations and Educational Institutions.

Another meeting was held on March 14, 1947, at Boston State Hospital, Mattapan, at which time it was voted to change the time of the annual meeting from November of each year to March, April or May in order to parallel the time of its election of officers with that of the majority of state associations. Since the membership is drawn from four states other than Massachusetts, it was voted also to remove the restriction in the By-Law regarding the location of Annual Meetings. The section which stated that meetings must be held within the state of Massachusetts was amended to include "or at such other place as the Board of Managers shall appoint."

A discussion was held relative to a change in whole or in part of the Constitution. It was agreed to give the matter consideration at the spring meeting.

The two guest speakers, Dr. Walter Barton, Superintendent of Boston State Hospital, and Dr. Elvin Semrad, the Medical Director, had much to say that was of interest to those concerned with the administration and practice of Psychiatric Occupational Therapy. Dr. Semrad, in his paper "Occupational Therapy as an Aid to Psycho-Therapy," stressed the importance of certain factors in the attitude and personality of the therapists that could have therapeutic effect upon patients. Dr. Barton urged the attending members to consider the possibilities of maximum use of O.T. in state hospital programs participating in the development of total activity programs in conjunction with recreational and industrial training groups. Despite the current shortage

of personnel and budget, he struck a welcome note of optimism for state hospital staff workers.

The annual spring meeting, which was an all-day session, was held on May 9th at the University of New Hampshire in Durham. The day began with a short business meeting where one of the subjects discussed was the proposed formation of a New England Occupational Therapy Association. It was suggested that further consideration be given before any plans are definitely carried out.

The business meeting was followed by a welcome from President Harold W. Stoke who also described the inception of the Occupational Therapy Training program at the University. Dean Bluett discussed some of the details of the O.T. Curriculum.

After lunch student occupational therapists led small tours of the campus showing us lecture rooms, workshops and a fine exhibit of craft work. This was followed by a movie on placement of handicapped persons, and by tea in the Craft House.

All members present were greatly impressed with the program the University of New Hampshire is offering occupational therapy students and returned home with a feeling of pride in our profession.

SPECIAL GROUPS

ARMY

H. Elizabeth Messick, O.T.R., Editor

ARMY TO COMMISSION OCCUPATIONAL THERAPISTS

Occupational therapy has proved its worth to the Army. Recognition of this is demonstrated by the inclusion of Occupational Therapists in the Women's Medical Specialist Corps recently authorized by Congress.

Civilian occupational therapists have been employed by the Medical Department of the Army since World War 1. A school for postgraduate training of such personnel was maintained at Walter Reed General Hospital until the Economy Act of 1933 abolished the school and curtailed occupational therapy programs in all Army hospitals by reduction in civilian personnel.

At the time of the United States' entry into World War II, only twelve occupational therapists were on duty in Army hospitals. In recognition of the increasingly urgent need for an occupational therapy service in the Army, personnel was steadily increased until, on V-J Day, 899 carefully selected, professionally trained therapists were on duty in Army hospitals. More than half of this number were occupational therapists trained by the Army in its government sponsored and subsidized War Emergency Course.

Specifically, the bill provides for permanent commissioned status in the Regular Army for nurses, physical therapists, dietitians, and occupational therapists. It also provides for the establishment of a Reserve Corps for the Army Nurse Corps and the Women's Medical Specialist Corps similar to the Reserve Corps now in effect for other branches of the Army.

The bill provides for an authorized strength, in both the Corps, in suitable proportion to the total authorized strength of the Regular Army.

The Directors of the Army Nurse Corps and the Women's Medical Specialist Corps shall be in the grade of Colonel; the Directors of the three sections of the latter Corps shall be in the grade of Lieutenant Colonel. Appointments to both Corps shall be in the grade of Captain to Second Lieutenant, inclusive, with a limited number of officers in the rank of major, to be appointed by selection. Determination of rank shall be made on the basis of age, experience, and service.

Permanent commissioned rank will entitle the nurses, physical therapists, dieticians, and occupational therapists to the same benefits enjoyed by male officers, including allowance for dependents, disability and longevity retirement privileges, commutation of quarters and leave benefits.

All occupational therapists desiring to accept commissions in the Regular Army or the Officers' Reserve Corps must make application for commission. Those now on duty in Army hospitals will be the first to be "integrated." Those who served with the Army during the war and wish to make application will be given next consideration for integration. Applicants who have not previously served with the Army must be between the ages of 21 to 28 and have a bachelor's degree.

The occupational therapy requirements for application will be:

1. Graduation from a school of occupational therapy approved by the Surgeon General and certificate of registration by the American Occupational Therapy Association.
2. Physical and moral qualifications of an officer.
3. No dependents under fourteen (14) years

of age.

4. Ability to pass designated measurements of professional qualifications such as:
   a. Technical examination in occupational therapy.
   b. Personality analysis.
   c. Personal interview.

Application blanks will be distributed to the six Army Headquarters, to all general hospitals within the continental limits of the United States, and will be available upon request from the Surgeon General's Office, War Department, Washington 25, D. C.

The improved status of the occupational therapist and the increased opportunities for professional advancement offered by the establishment of an Occupational Therapists Section in the Women's Medical Specialist Corps of the Regular Army should more than compensate for two factors which are frequently interpreted as disadvantages to acceptance of a commission in the Regular Army. These are the obligations implied by acceptance of a commission as related to length of service and assignment and transfer. With regard to the former, a commission in the Regular Army is theoretically accepted for life, however, resignations will be accepted when just cause for such request can be shown. In the matter of assignment, personal preference as to placement is given every consideration unless such preference does not coincide with military necessity.

The War Department believes that this legislation will provide that peacetime medical service to the nation's military men be maintained on the highest possible level of medical and nursing care.

VETERANS

Jane E. Myers, O.T.R., Editor

Veterans' Administration Pre-convention Date. Plans are being formulated to have a one-day meeting prior to the Annual Convention in the Hotel Del Coronado for Veterans' Administration occupational therapists and any others who are interested in Veterans' Administration problems and progress. The meetings for the day will be composed of talks presenting and discussing the varied programs found in the Veterans hospitals. It is hoped that we will have twice the number of occupational therapists from our hospitals that we had at the Chicago meeting last year.

Advisory Committee. Dr. Walter E. Barton, Superintendent of Boston State Hospital, Chairman; Mrs. Winifred Kahmann, President of AOTA; and Miss Sue P. Hurt, Educational Secretary of AOTA, have accepted appointments as members of an advisory committee for occupational therapy in the Veterans' Administration. This follows the policy of VA to secure leaders in the medical professions on consultant and advisory bases for the many departments.

Personnel Survey. The Personnel Survey, just completed, shows that we have occupational therapy departments in 120 of the 124 hospitals in the Veterans' Administration. There are qualified therapists in 116 of these hospitals.

Chief Therapists in Branch Offices. Four Branch Offices now have a Chief of Occupational Therapy who are:

New York, N. Y.—Miss Elizabeth Smedes
Chicago, Ill.—Miss Mary McDonough
St. Louis, Mo.—Miss Leonelle Gamble
Dallas, Texas—Miss Mary Britton

Professional Rating. The long-awaited reclassification specifications for occupational therapy positions have been announced. This gives professional status to qualified therapists. These new specifications for occupational therapy positions are the result of an extended survey of field positions. The most important job for each therapist now is to prove she is worthy of professional status and that the work she does is an adjunct to medicine and worthy of professional rating.

Clarification of Purpose and Objectives. Some recent discussions on the need of clarifying purpose and objectives of occupational therapy have brought out these suggestions:

Definition: Occupational Therapy is the treatment of disease or injury, either physical or mental, by the scientific use of remedial activities, such as properly selected and adapted craft.

Function: The function of occupational therapy is to provide, as prescribed by a physician, scientific, purposeful and constructive, activity that will promote—

1. Physically: restoration of muscle tone, joint motion and development of coordination;

2. Mentally: release from mental and emotional strain;

3. Socially: motivation back to normal life.

Principles: Principles governing occupational therapy are:

1. Prescriptions by a physician based on the individual needs of the patient;

2. Activity must be definitive, purposeful, and constructive;

3. Equipment must be properly selected and adapted to meet the individual needs of the patient.

U. S. PUBLIC HEALTH

A. William Reggio, M. D., Editor

As the Rehabilitation Program progresses, two of the greatest difficulties are (1) to find qualified therapists in the position of Chief or Assistant for the location where they are needed, and (2) to increase the ceilings at stations to permit an increase in the personnel authorized.

Frequently a therapist enquires as to a possible position but when informed where the opening is, interest ceases as they do not want that locality. Also the applicant will specify a certain place where at the time there is no position open. This preference is of course only natural but it does make recruiting more difficult.

It would be so nice if it were possible to place all qualified applicants in the place and grade acceptable to them. Unfortunately, however, it does not seem to work that way and as a result progress is somewhat slowed down.

In the Civil Service Application Form No. 57 which is now being used for all applicants for positions, item number 15 (a) enquires whether the applicant would accept a short term appointment of 1-3; 3-6 or 6-12 months, 15 (b) enquires whether an appointment would be accepted in Washington, D. C.; anywhere in the United States; outside the United States. 15 (c) says "If you will accept appointment in certain locations ONLY, give acceptable location." 15 (d) says "What is the lowest entrance salary you will accept?"

From the replies it becomes quite clear that when a position is open — let us say — in New York and the applicant states in 15 (c) that only San Francisco will be considered there is but a very slight possibility of interesting the applicant further. When, however, a qualified applicant is willing to accept employment *anywhere* in the grade of a position that is open — then one almost begins to wonder where the catch is! This does *not* occur frequently!

It is also interesting to observe how many application forms are received where the applicant has failed to fill in replies on a number of items. Why they ignore the simple instructions to answer *every* question is a mystery yet to be solved because failure to give complete information necessitates the return of the application form with a polite request to kindly supply the missing information. When all pertinent information is presented, then the application can be reviewed and not before.

This does not seem unreasonable besides which if an applicant is careless about completing an application it is quite possible that a similar lack of thoroughness may prevail in that individual's pursuit of her profession.

ACCREDITED SCHOOLS OF OCCUPATIONAL THERAPY

and those with Accreditation Pending

School (and Department)	*Address of School*	*Director*
Boston School of Occupational Therapy Affiliated with Tufts University	7 Harcourt Street Boston 16, Mass.	Mrs. John A. Greene, Director
Columbia University College of Physicians & Surgeons	630 West 168th Street New York 32, N. Y.	Miss Marjorie Fish, O.T.R., Director of Training Courses in O.T.
*Iowa, State University of College of Medicine	Div. of Physical Medicine Iowa City, Iowa	Miss Marguerite McDonald, O.T.R., Occupational Therapy Supervisor
Illinois, University of College of Medicine	1853 West Polk Street Chicago 12, Ill.	Miss Beatrice D. Wade, O.T.R., Director, Department of O.T.
Kalamazoo School of Occupational Therapy of Western Michigan College of Education	Kalamazoo 45, Mich.	Miss Marion R. Spear, O.T.R., Director of O.T.

ACCREDITED SCHOOLS OF OCCUPATIONAL THERAPY

Kansas, University of	School of O.T. Lawrence, Kan.	Miss Nancie B. Greenman, O.T.R. Director of O.T.
Michigan State Normal College	Ypsilanti, Mich.	Miss Gladys Tmey, O.T.R., Supervising Director of O.T.
Mills College	Oakland 13, Calif.	Miss Arlene J. VanDerhoef, O.T.R., Director of O.T.
Milwaukee-Downer College	2512 East Hartford Ave. Milwaukee, Wis.	Prof. Henrietta McNary, B.S., O.T.R., Director of O.T.
*Minnesota, University of School of Medicine	Minneapolis, Minn.	Miss Borghild Hanson, O.T.R., Director of O.T.
Mount Mary College	Milwaukee 13, Wis.	Sister Mary Arthur, O.T.R., Associate Professor, Director of O.T.
New Hampshire, University of College of Liberal Arts	Durham, N. H.	Miss Doris F. Wilkins, O.T.R., Supervisor of O.T. Curriculum
New York University School of Education	Washington Square New York 3, N. Y.	Miss Frieda J. Behlen, O.T.R., M.A., Director of O.T. Curriculum
Ohio State University College of Education	105 Arps Hall Columbus 10, Ohio	Miss Martha E. Jackson, O.T.R., Associate Professor, Chairman, O.T. Department
Philadelphia School of Occupational Therapy Affiliated with University of Pennsylvania— School of Education	419 South 19th Street Philadelphia 46, Pa.	Miss Helen S. Willard, O.T.R., Director
*Puget Sound, College of	N. 15th and Warner St. Tacoma 6, Wash.	Miss Edna-Ellen Bell, O.T.R., Director of O.T. and Rehabilitation
*Saint Catherine, College of	St. Paul 1, Minn.	Sister Jeanne Marie, O.T.R., Director of O.T.
San Jose State College	San Jose 14, Calif.	Miss Mary Booth, O.T.R., Asst. Prof. in O.T.
Southern California, University of College of Letters, Arts and Sciences	Box 274 Los Angeles 7, Calif.	Miss Margaret S. Rood, O.T.R., Head, Department of O.T.
*Texas State College for Women Department of Art	Denton, Texas	Mrs. Fanny B. Vanderkooi, O.T.R., Associate Professor, Supervisor of O.T.
Toronto, University of Department of University Extension	Toronto, Canada	Miss Helen D. LeVescente, O.T.R., Supervisor, Course in O.T.
Washington University School of Medicine	4567 Scott Avenue St. Louis 10, Mo.	Miss Dorothy L. Flint, O.T.R., Acting Director, Department of O.T.
*Wayne University College of Liberal Arts and College of Education	Detroit 1, Mich.	Miss Barnara Jewett, O.T.R., Asst. Professor, Director of O.T.
William and Mary, College of Richmond Professional Institute	901 W. Franklin Street Richmond 20, Va.	Miss Helen Freas, O.T.R., Asst. Professor, Acting Director of O.T. Training
*Wisconsin, University of School of Medicine	1300 University Avenue Madison 6, Wis.	Miss Caroline Goss Thompson, O.T.R., Asst. Professor, Director of O.T.

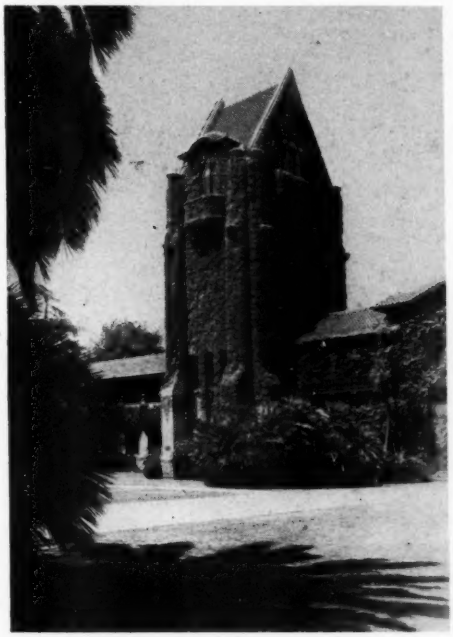
*Schools with Accreditation Pending.

SCHOOL SECTION

SAN JOSE STATE COLLEGE

San Jose 14, California

MARY D. BOOTH, O.T.R.,
Assistant Professor Occupational Therapy



San Jose State College is the oldest state educational institution in California. It was opened as a private normal school in San Francisco in 1857. Nine years later it was taken over by the state and renamed the California State Normal School. It was moved to its present site at San Jose in 1871. In 1921 the state legislature changed all normal schools to teachers colleges, and the following year San Jose State College granted its first Bachelor of Arts Degree. In 1935 the name was changed to San Jose State College and to a certain extent its functions were liberalized. In the past year the college has been authorized to give one year of graduate work and to grant a general secondary teaching credential.

The occupational therapy course is part of the Department of Natural Science. Its policies are determined by the Occupational Therapy Committee under the chairmanship of Dr. P. V. Peterson, Chairman of the Department of Natural Science and Dean of Professional Education. The other members of the committee are Dr. J. C. Elder, Dean of General Education, Dr. J. C. DeVoss, Dean of Student Personnel, Mr. Joe H. West, Registrar, Mr. E. S. Thompson, Controller, and the Director of Occupational Therapy.

Originally, San Jose State College offered three occupational therapy programs: A certificate course open to college graduates, a degree course open to high school graduates and a diploma course open to persons with one year of college work plus experience in an allied field. The diploma course has been discontinued. The degree course requires four years of academic work plus nine months of clinical training. The certificate course requires a minimum of one year of academic work plus nine months clinical training.

The first students were admitted to the occupational therapy course in the winter quarter of 1943. Mrs. Susan S. Richards, B.S., O.T.R., was in charge of the course. The curriculum was set up in accordance with the minimum standards of the Council on Medical Education and Hospitals of the American Medical Association. On June 11, 1944, the course was fully accredited. At the present time 23 of our graduates have taken the registration examination and 6 will take it in June. Ten students will receive a Bachelor of Arts Degree and 2 graduate students will be ready for clinical training at the same time.

The Occupational Therapy Department is particularly fortunate in its curriculum because it was able to take advantage of the excellent equipment and experienced faculty of many departments. Some classes were organized especially for occupational therapy stu-

dents and others were opened to them. Among the cooperating departments in the academic fields are the Natural Science Department, Social Science Department and the Psychology Department. A wide variety of skills are offered by other departments. Basic design and composition as well as ceramics, weaving, jewelry and other crafts are given by the Art Department. Woodworking, printing and bookbinding are taught in the Industrial Arts Department. A special course in social recreation has been organized by the Department of Physical Education. This course includes trips to the Veteran's Hospital at Palo Alto so that students may have practical experience in recreational planning and leadership. The Home Economics Department admits occupational therapy students to their courses in sewing, foods and table service, etc. Courses in photography, gardening, nature study and cosmetics are given in the Natural Science Department. In addition, students who are taking the degree course have an opportunity to elect courses in librarianship, education, dramatics and child development.

Medical information is given to the students through the courtesy of outstanding doctors in the city and in cooperation with Nursing Education. Besides the standard courses in theory of occupational therapy, students are required to take a year course in occupational therapy laboratory. The college offers a shop and homebound service in occupational therapy. Treatments are administered by senior students under the supervision of the Occupational Therapy Director. Each student is responsible for approximately three patients during the year. Cases of cerebral palsy, blindness, rheumatic fever, pulmonary tuberculosis and arthritis are given treatment under medical prescription.

The required clinical training includes experience in orthopedics, general medicine and surgery, psychiatry, pediatrics and tuberculosis. The affiliating hospitals are situated principally in the Bay Area but arrangements for training in other areas are occasionally made.

For the information of visitors to the National Convention, San Jose is situated 50 miles south of San Francisco and 450 miles north of Los Angeles on direct rail and bus lines between the two cities. Commuting trains and buses run frequently between San Francisco and San Jose. We would be delighted to have you spend a day on our campus either before or after the meeting.

KALAMAZOO SCHOOL OF OCCUPATIONAL THERAPY

of

Western Michigan College of Education

Kalamazoo 45, Michigan

MARION R. SPEAR, M.A., OTR., *Director*

It is most fitting that June should have been selected for a history of the Kalamazoo School of Occupational Therapy, for it was 25 years ago this month in 1922 that plans for the school were developed and the first class of two students enrolled, one a registered nurse from Minnesota, and the other a recent graduate of the University of Michigan.

The school or course as it was first called, was planned primarily to train students who might fill the ever-increasing needs of the occupational therapy department at the Kalamazoo State Hospital. It is true that at first emphasis was placed on training students for psychiatric work, but as graduates continued to be in demand for other fields the program was expanded to include new subjects. From the time that minimum standards were established by the A.O.T.A. the Kalamazoo School has always more than met the requirements.

With the opening of the school, students were fortunate in being able to live in the hospital and observe the interrelationship with other departments, a situation that is possible only through daily contact. Medical, psychiatric and biologic sciences were studied under the direction of the well equipped medical staff of the hospital. Psychology, both general and abnormal, lectures and first hand exposure to the functioning of a well developed social service department were a part of the student's training. She received her theory and didactic training in the crafts from occupational therapists, and actively shared in a well planned program of recreation such as only a large mental hospital can offer. An adult education program, the hospital newspaper, and whatever had to be done at the moment were there for her active participation. She was able to

apply her knowledge and skills as they were learned.

From time to time the course was lengthened and adequate clinical training in other fields was established. Because of her months of continuous residence at the Kalamazoo State Hospital it was possible for her to spend at least three months in other types of hospitals and thus her practical experience extended from the time of entrance until graduation.

The growth of the school has been steady. It is the only school started within a hospital that has continued to function and is one of the first five schools in the United States to be approved by the American Medical Association.

As early as 1929 steps were made toward affiliation with Western Michigan College of Education, the largest Michigan college of education situated on the land adjoining the hospital grounds. At that time extension courses with college credit were given to the students at the hospital by faculty members of the college. These courses were in addition to those already given at the hospital and included advanced work in psychology and the sciences. A few years later students were required to attend classes on the campus for two semesters, attending classes a half day a week and devoting the other half day to further study and clinical training at the hospital. Following this arrangement the college allowed a substantial amount of credit for lectures and theory done at the hospital. This was the beginning of the degree course and in 1937 the first student to graduate under such an arrangement completed her work. Since that time the majority of students have completed the degree course. In the same year all O.T. students were required to have one and preferably two years of college work before entering the school.

In keeping with the growth of the school, and at the invitation of the President of Western Michigan College, the Kalamazoo School of Occupational Therapy became a department of the college in October 1944. With the school went the one and only director that the school has had, and her assistant, also a registered O.T. In two years time the staff had increased to three registered O.T.s and one master craftsman assigned to the department. Two of the four also have their Master's degree. All theory, kinesiology and crafts are taught by registered O.T.s so that it is possible to integrate theory with didactic work. The biologic, social and psychologic sciences are taught by members of the science sociology and education departments. Courses in psychiatry and neurology and medical diseases are given at the State Hospital by men well equipped with knowledge in those fields.

The undergraduate may now choose one of three different curricula: the diploma course, or the degree, with or without the teacher's certificate. The prerequisite for all three curricula is one year of work acceptable to the college, in addition to rigid personal requirements. A careful screening of all applicants is augmented by psychological and aptitude tests.

The degree curriculum is so arranged that the student may complete her course, including nine months of clinical training, in four calendar years. Clinical training is generally started between the second and third years and is completed during the fourth year of residence. An extra semester of practice teaching is required of those who desire a teacher's certificate. This is made possible at the well equipped Ann J. Kellogg School in Battle Creek.

Students who have already earned a degree are admitted twice a year in the advanced standing program. This consists of two semesters (more, if necessary) of work on campus and nine months of clinical training.

No effort has ever been made to recruit students. Until the school was moved to the college two-thirds of the students enrolled were from other states. They have come from 36 states and from Canada, Hawaii, Puerto Rico, England, France, Switzerland and Korea. Graduates of the school have held or are now holding positions in 36 states and the foregoing countries, although not necessarily in the same state or country from which they came.

The school is especially proud of its graduates who served in the armed forces and of those who are now in educational work in O.T. schools or who are taking the lead in the clinical training field where experienced therapists are so badly needed. If we are to give our present students the best there is, we must not overlook the importance of this area. There is a challenge for us all if we are to meet the needs of the future.

STUDENT COLUMN

Editor, Helen Harvey

MILWAUKEE-DOWNER COLLEGE
MILWAUKEE, WISCONSIN

SOMETHING NEW

Culminating five years of preparation for professional life the Milwaukee-Downer class of 1947 spent its last five weeks together, whipping theory and practical experience into a well-rounded whole. Theory now tested, knotty problems met during the months of clinical training and occupational therapy department arrangements in the same types of hospitals were discussed. All this is for common and individual enlightenment. The last phase of student life terminated on June ninth when student badges were fondly removed from white uniforms for the graduation ceremony.

The first two days of this new venture were spent at the Tri-State Hospital Assembly in the Chicago Palmer House. Attending the general hospital conferences during the morning and meetings on occupational therapy in the afternoon enabled students to broaden their views and meet medical personnel from the Illinois, Wisconsin, Michigan and Indiana areas.

After the initial reunion excitement of nineteen potential registered occupational therapists died down on the morning of May seventh Miss McNary, Director of Occupational Therapy, greeted the class and outlined the remaining program. Meetings opened every morning in the seminar room of the lovely Chapman Memorial Library at eight-thirty and continued until noon. There was a review and discussion of four phases of the field. Each week entailed the study of a separate phase and was terminated by an examination. A detailed outline of each of the four divisions guided the study of (1) Medicine and Surgery, (2) Orthopedic and Traumatic Conditions, (3) Psychiatry, and (4) Pediatrics. Rehabilitation was included in the survey of each division. Supplementing the discussions were medical lectures given to the seniors which the class is privileged to attend, as well as special speakers on requested subjects.

When not concentrating on the area to be covered from day to day the time is spent writing and re-writing theses. The outlines, prepared last February, were filled out and cries of "My subject keeps expanding" were serious problems. By the first of June nineteen papers were most reverently placed in the care of the director.

By Marjorie MacMichael

COLUMBIA UNIVERSITY
NEW YORK, NEW YORK

THE MINORITY MALE

The following is based on an authentic interview with Steve Lopez, a first year O.T. student from Porto Rico.

Steve completed three years of pre-medical work in Porto Rico. He had a friend who was a physiotherapist there. After consulting the director of the training course Steve decided to go into O.T. rather than complete his medical work. He intends to complete his study in O.T., then get his M.D. and finally to combine both into a career.

Through Steve's eyes we caught a glimpse of Porto Rico and the conditions as he left them. There are no medical schools there. Students pursuing this course must further their education in the States or abroad. Some P.T. was introduced before the war and O.T. is nonexistent. He plans to go back to Porto Rico when he completes his training and pioneer O.T. there.

Steve has his own views on being the only male student in the first year class. He believes that the advantages are lack of competition and the disadvantages, lack of good male support.

MEET ANOTHER MALE O.T.

A rare and wonderful thing is a male O.T. His female fellow students with the native curiosity of their sex had to know what prompted the competent Mr. Competello, Advanced Standing student, to plunge into a field billowing with women's skirts.

His debut in O.T. came when he was serving a tour of duty at the St. Alban's Naval Hospital. To his new vocation he brought hands wealthy with the skill of the carpenter (a treasure he had absorbed from his father), the technique of a modern foundry (learned in the practical school of experience), and a background enriched by studies in the arts in high school and college. The Navy reciprocated these gifts by generous experience in the field. At St. Alban's he trained and observed the diverse program of a general military hospital; at Brooklyn State Hospital for the mentally ill he was in charge of the woodwork shop. At Charleston, S. C., he set up an O.T. shop.

As a civilian he has chosen to remain in this field for very solid reasons: (1) The vast number of patients are men. (2) The techniques and crafts of O.T. are essentially masculine interests. (3) The almost forgotten but desperately needy field of O.T. in Penal Rehabilitation is properly a male domain. (4) He likes O.T.

He believes that in the future more men will enter O.T. and will be drawn from the ranks of those who contacted O.T. in the service. The increasing emphasis on Pre-Vocational and Industrial Therapy will induce more men to the field. It is his opinion that the current level of O.T. has discouraged men in the past. If more men enter the field their presence will tend to raise salaries in general.

Although more men in O.T. would be desirable in more than one way Mr. Competello said that women should outnumber the men. When pressed for a reason he declared that their manner is naturally more persuasive and their efforts in getting cooperation more successful oftentimes than those of a man. What wisdom, what diplomacy! We repeat, a rare and wonderful thing is a male O.T.

WASHINGTON UNIVERSITY
ST. LOUIS, MISSOURI

OUR MR. "B"

Mr. Burgess was an Industrial Arts major in college. He came to within twenty-two semester hours of receiving his degree; however, he interrupted his course to accept a teaching position at a junior high school, where he taught industrial arts for a year and a half.

In 1942 Mr. "B" joined the army. While overseas he was injured and hospitalized. Here he came in contact with O.T. for the first time through the Red Cross Workers and special service men, who carried on work very similar to ours.

Several months later Mr. "B" was returned to the states. He learned more about occupational therapy at Madigon General and spent most of his time in the O.T. shop. He found O.T. fit well with his previous training and soon began investigating the field, thinking of it as a possible career for himself. He decided there was but one drawback. "Women, women, women — they seem to have the field pretty well sewed up, but if they can stand it I can."

By Ann Hample

ORGANIZATION AND ADMINISTRATION

Marguerite Abbott, O.T.R., Editor

In the previous article on organization and administration a tentative teaching outline was given which might serve as a common denominator for various units of instruction in this area.

Ideally a course such as this should not be given until the student has reached her senior year of training and has had some clinical orientation in the professional field. Fundamental working principles and criteria in this area will then be comprehended much more quickly if the student has had an actual working contactual experience in the field. Students should be equipped with factual information of this subject before they graduate, and not rely upon the hit and miss empirical methods of organizing a department without any specific instruction relative to the working knowledge of the cardinal principles of organization and administration.

To understand how to organize an O.T. department one must first understand what is meant by the general concept of organization and its integration with the hospital institution as a whole. By organization we mean "to arrange or constitute in independent parts, each having a special function, act, or office, in respect to the whole: to systematize and to get in working order." Thus a well organized department is one in which there is a smooth flow of routine work, proper delegation of authority, and a definite time and place for all departmental functions. Proper planning is the keynote of good organization. Each staff member knows precisely what her duties are, and what is expected of her. Weekly staff meetings are helpful, if not imperative, if a department is to run as an intelligent, whole, cohesive group, with the object in view of rendering the best possible service to the patient.

William H. Burton, Ph.D.,[1] gives seven general principles of administrative organization which are: 1. Executive responsibility must be definitely centralized. 2. Lines of authority must be clearly defined. 3. Authority must be definitely delegated. 4. Duties must be definitely assigned, and performance checked. 5. There should be facility for cooperation. 6. There must be flexibility of operation. 7. There should be integration of desired outcomes.

"Executive responsibility must be definitely centralized." This refers to the chain of command being cleared through the proper channels, chain of command meaning orders from the chief, to the assistants, thence to the subordinates. In every department there must be a central clearing desk over which all of the ramifications of the details of running an organization must flow. The central clearing desk is that of the director of the department. This is the pulse of the department and from which the initial orders ensue. This should be followed up by proper supervision, which unifies orders given, with their proper execution. Thus, centralization of authority is necessary for the intelligent and cooperative functioning of a department.

"Lines of authority must be clearly defined and definitely delegated." This means that there is a smooth flow of authority from the director to all staff members, which is clearly understood. Gaps and overlaps in the line should be avoided. Duplication of duties leads to confusion and a waste of time. Duties should be delegated definitely to specific staff members for execution.

"Duties must be definitely assigned and performance checked" is one of the most important phases of good direction. When a Therapist is given a duty to perform she should do it to the best of her ability, as quickly as possible, and through the proper channels. When that duty is completed, or if it is impossible to execute, the proper procedure is to check-back to the source from whence it came, and report reasons for same.

"Facility for cooperation, flexibility of operation, and integration of desired outcomes," refers to the policy of the department of having regular staff meetings in which the staff members are given the opportunity to express themselves on matters of policy, based on the democratic basis of free discussion. Allowance must also be made for the originality, initiative,

[1] N. L. N. E. Report 1931, pp. 186-187.

and variation of the personalities of the staff members. And finally there should be a common departmental policy of a communal grasp of the techniques and procedures of the department, which is understood by all staff members.

To summarize, the basic premise of general organization comprises four broad points: centralization of authority, duties definitely assigned and performance checked, delegation of authority and facility for cooperation.

References:

Kahmann, W. C. *Organization and Administration of Occupational Therapy*, O. T. & R. June, 1936.

MacEachern, Malcolm. *Hospital Organization and Management*, Physicians Record Co. Chicago. 1935.

SPECIAL NOTICES

Nell McCulloch, O.T.R., of the Curative Workshop, Louisville, Kentucky, is sending out an S.O.S. for an old fashioned bicycle saw, of the type made by Barnes and Co., of Rockport, Illinois, which she describes as having "a large wheel, a tractor seat of cast iron, rides like a bicycle and has a large table to hold wood while sawing." She can pay for it, too!

VACATION AND STUDY GROUP TO MEXICO
July 16 — August 8

The International School of Art is offering a Mexican trip for O.T.'s. The tour will be conducted by Mrs. Ethel H. Sanford, O.T.R., a graduate of the St. Louis School, and until recently, Chief Aide at the Veterans Administration in Los Angeles and San Fernando. Occupational therapists will have an opportunity to exchange ideas with the art group who will cover approximately the same territory.

Starting from the Hotel Regis, four days will be spent in Mexico City where there will be a general instructive and recreational program accompanied by visits of special interest to O.T.'s. After a stay in Taxco (reach via Cuernavacca) the trip proceeds to Guadalajara where the Tonalteca potters offer their hospitality. Indian and Spanish homes are open to members of the party, as is the fiesta with its Tlaquepaque dancers. There is an excursion to Chapala and Ajijic to add further interest to the trip.

The cost of the trip is $330.00. Further details of the trip which is titled "Art and Science" may be obtained from The International School of Art, 522 Fifth Avenue, New York City, N. Y.

The United States Public Health Service is inaugurating a physical medicine program at the Leprosarium. Carville, Louisiana. This will be a research program, with special emphasis upon the use of Physical and Occupational Therapy in the treatment of the peripheral nerve lesions so frequent in Hansen's disease.

Details are not completed, but an applicant may figure upon a probable minimum salary of $4,000.

This should prove to be an extremely interesting and professionally valuable project.

It is hoped that some of our members will be sufficiently interested to write the national office from which will be forwarded any applications or inquiries to the proper authorities.

FIELD THERAPISTS NEEDED!

Many people are of the opinion that one of the coming fields of service in occupational therapy is with the severely disabled homebound. In the two years since the inception of its homebound program, the Michigan Society for Crippled Children and Disabled Adults has reached out with its occupational therapy service to include some of this widely scattered group in 30 counties of the state, but additional staff is badly needed in order to reach even the most deserving of the homebounds in the rest of the state, which comprises 83 counties in all. Experienced therapists are preferred for this specialized field, which offers an exciting challenge to O.T.'s who have wearied a bit of the confining atmosphere of an institutional position, and who like to travel, and yet who want to keep that close patient contact which individual home service therapy gives. This field also offers to the experienced O.T., or to the young graduate, fascinating sociological study, as referrals are constantly made from and to the various health and welfare agencies of the community, and there is much opportunity to learn first hand of the medical, physical, social as well as craft and vocational possibilities for the disabled in the various communities in which one works. Anyone interested in one of the several openings in this field in Michigan should write to Janet M. Paterson, O.T.R., Michigan Society for Crippled Children and Disabled Adults, Inc., 449 W. Ferry, Detroit 2, Michigan.

NEW BRAILLE WRITER

It is now possible to obtain the Banks Pocket Braille Writer which weighs one and a half pounds, is seven inches long, four inches wide, and one and a half inches high. It can be carried in a man's coat pocket or a lady's handbag. This Writer is manufactured by International Business Machines Corporation in New York City, and is distributed through Lions Clubs. The actual cost of the machine is $18.00 but the Lions Clubs have agreed to sell them for a maximum of $5.00 to a blind person. It operates on the ticker tape system and is noiseless. It should prove to be very useful to college students or persons in busi-

ness who need to take short notes. Application for a Writer should be made through your local Lions Club.

FIRST OCCUPATIONAL THERAPISTS COMMISSIONED IN REGULAR ARMY

The Adjutant General of the Army is ready to receive applications from occupational therapists (unmarried) who desire appointment in the Occupational Therapists Section of the Women's Medical Specialists Corps. This is under Public Law No. 36.

If you have served honorably with the Army at any time since 7 December, 1941, as an occupational therapist, you will be given special preference for appointment to fill the authorized Regular Army vacancies. Integration application for No. 102 must be filed before 31 July, 1947. Benefits relative to integration will not apply to applications filed subsequent to 31 July, 1947.

Following integration, new appointments in the Women's Medical Specialists Corps will be made from members of the Officers Reserve Corps. Occupational therapists under thirty-five, who served with the Medical Department during World War II, and other qualified occupational therapists under twenty-eight, are eligible for appointment in the Officers Reserve Corps. Application for either corps may be obtained from the Occupational Therapy Branch of the Surgeon Generals Office, Washington 25, D.C., from Army General Hospitals, or from the A.O.T.A. office.

Upon satisfactory completion of the screening requirements you will be offered a commission in the Women's Medical Specialists Corps. The commission so offered may be accepted or refused.

A COMMISSION IN THE REGULAR ARMY MAY BE RESIGNED AT ANY TIME. This is not to be confused with present commissions in the A. U. S. where length of service is determined by duration of emergency and where release from service is otherwise regulated by the category system.

The advantages of the Regular Army commission status include: the personal benefit of medical care, travel expenses, retirement pay, and the professional benefits or further training, refresher courses, and the stability afforded to long-range planning for special programs.

EVENTS CALENDAR

JULY 6-12, 1947

American Physiotherapy Association, Annual Conference, Asilomar, Pacific Grove, California.

SEPTEMBER 2-6, 1947

American Congress of Physical Medicine, 25th Annual Session, Hotel Radisson, Minneapolis.

SEPTEMBER 7-12, 1947

American Association of Medical Record Librarians, Hotel Commodore, New York City.

NOVEMBER 2-7, 1947

American Occupational Therapy Association, Annual Convention, Hotel Del Coronado, Coronado, California.

O.T. CLINIC

"PAY FOR WORK"

Do you agree with this?

"In institutional occupational therapy shops, many useful and attractive handcraft projects are undertaken under the supervision of trained workers. If the articles made are sold, sometimes a small percentage of the profits is turned over to the patients. Some handicapped patients and invalids are benefited by the consciousness that they are actually working — it stabilizes and normalizes them; other patients are adversely affected, especially by working under pressure to complete articles for sale. The program should be adjusted in all cases to the individual."

OUTLINE OF INDUSTRIAL SURVEY

There is perhaps no more controversial subject than that of industrial therapy in State Hospitals, considering the different points of view from which it is approached by therapists. How many occupational therapy departments

would want to fill out, honestly and factually, the following "Outline of an Industrial Survey Used in the Clinical Training Program, Fairfield State Hospital, Newtown, Conn."

Unit .....No. Employees .....
No. paid employees .....No. unpaid employees .....
No. needed .....

I Work performed by paid patients, and time on this special job

II Work performed by unpaid patients and time on this special job

III Basic requirements of the job
JOB.....
Mental Strain involved
Emotional Strain involved
Skills required
Levels of work (one activity) (simple) (exact) (complex) (integrated)
Description
Total duration (season) (intermittent) (continuous)
Length of work period
Progression within job
Is any report of progress and workmanship made?
How often? To whom?
How (telephone, written)
Is any attention given to change of work?
Yes No
Suggested advance?
Placed on payroll? Yes No
Shift in field of interest? Yes No
Explanation

IV Work Environment

V Equipment (adequate) (inadequate) (excessive)

VI Can any of this work be done on the wards?
Supervision?
Are more patients needed to do an adequate job?
Can more patients be employed? (male) (female) (for training)
Can patients in following groups be employed safely? (aments) (mild psychotics) (regressed) (seniles) (epileptics)

VII Assignment of Work?
Who assigns work? (supervisor) (patient supervisor) (ward charge)
Basis of assignment?
Educative (training program)
Productive (because of pressure of work)
Palliative (to divert excessive self-concern)
Habit training (personal hygiene)
Care of equipment
Personal Stability

VIII Precautions enforced;
Tool
Escapes;
Self-harm;

IX Therapeutic results
Considered by the supervisor?
Patient relationship
Employee relationship
Quality of workmanship?
Individual gains;
Concentration
Ego-building experiences
Improved attitudes
Ward Illness Work
Hospital Other patients
a job "outside" Community
Ind. responsibility
Extraverting experiences
Socialization-ability to take part in group experiences

X Suggestions for improvement or extension

CHESTNUT LODGE

Who can offer from her experience an explanation for the success of the art classes we have organized at Chestnut Lodge? Let me first briefly explain the situation and then present the questions which we cannot altogether answer.

Ours is a small psychoanalytically-oriented sanitarium. We have two art groups, both of which work from a "portable" still-life. One group consists of the more disturbed patients who work with pastels or charcoals on their floor for hourly periods twice a week. They are given the opportunity of voluntarily creating their own arrangements at each meeting. The less disturbed group gather in the O.T. shop and work up to three hours on two consecutive days with the same still-life but they employ either water color or oil. This time arrangement allows the slow painters to complete their work, while the fast colorists have an opportunity to try the same arrangement again.

The groups have these characteristics in common: they each have many patients who have seldom or never participated greatly in occupational therapy activities (but who have become more active in occupational therapy since their participation in the art groups). They work quietly, with conversation limited to suggesting techniques to each other and sharing very honest criticism. Competition is apparently minimal. Many patients tolerate longer periods of work in the art groups than in other occupational therapy activities. There seems to be no indication that previous experience affects the membership, inasmuch as some patients

have had no practical art experience and some have studied many years. Productions seldom show marked pathological characteristics, and usually differ from "normal" work by a display of much greater freedom.

Instruction, which is given by an enthusiastic person trained in the fine arts, is usually limited to casual suggestions and encouragement. Fairly frank criticism is given only when requested. The instructor participates as much as time allows, but is not usually conspicuous by "better" productions.

In general, why are patients more responsible to art groups than to other occupational therapy activities, showing less feeling of competition, longer work tolerance, more cooperation? Why is their work more bold and free than in similar groups of "normal" art students? What role does the instructor play in such a group? These art classes create many more questions to share in this clinic column than space allows.

It is hoped that our assembled material and conclusions, added to your contributions, may produce a real article on this subject in the near future. *Edith A. Onthank, O.T.R.*

"HAVE YOU TRIED?"

Somewhere in the following list may be the suitable activity that you have been trying to think of for that special invalid or handicapped patient.

Art
Auto rides
Basketry
Beadcraft
Bird House Construction
Bird Walks
Block Printing
Book Binding
Bubble Blowing
Charades
Checkers
Chess
Clubs: Camera, choral, coin, book, stamp, travel
Croquet
Discussion Groups, current events, literary, sports
Dominoes
Dramatics
Entertaining Programs
Fibrecraft
Fingerpainting
Gardening, in and outdoor
Hiking
Holidays, celebration of
Jewelry Making
Kite flying and making
Knot tying crafts
Leather crafts
Letter writing clubs
Library
Metalcraft
Model Making
Modelling and Pottery
Music Activities
Musical Instrument Making and playing
Naturecraft and walks
Needlecraft
Papercraft
Parties
Pets
Photography
Picnics
Puppetmaking
Puzzles
Quilting
Quoits
Radio
Reading
Records, listening to
Scrapbooks
Shadow plays
Shuffleboard
Soap Sculpture
Sponge craft
Story Telling
Toys
Toy making, cloth, wood
Trips: fishing, sightseeing, swimming, visiting
Weaving
Woodcarving

From National Recreational Association

SHOP HINTS

In searching for a solution to make block printing ink more color-fast, the following was discovered: to a pint of turpentine, add an ounce of oil of wintergreen and an ounce of glacial acetic acid. This is mixed with the ink on a glass or tile before printing. Only about a teaspoonful of the solution is needed to every inch of ink squeezed from the tube.

Bendix dental polishing powder is excellent for putting the final finish on plexiglass. It is inexpensive and can be obtained through dental supply houses.

Antje Price, O.T.R.

Windowpainting, using isolated figures without a background, is an effective means of seasonal hospital decoration, especially if done on "inside" or partition and cubicle windows; "outside" windows tend to sweat, and dissolve the paint.

Antje Price, O.T.R.

To improve the appearance of storage cupboards with glass doors that looked miscellaneous and messy even when materials and boxes were neatly stacked, we stencilled a design on the panes and filled in the background to match the woodwork or "shop color." All this was done with rather thick poster paint, which is not only fairly permanent, but can be easily removed by scraping with a razor blade. The painting was done on the inside of the windows, so that under ordinary circumstances, when they were closed, the painting was seen through the glass. It gave not only a neater, but also a lighter appearance to the shop.

Antje Price, O.T.R.

Do You Know That . . . .

BALTIMORE SUN REVIEWS WORK OF DR. DUNTON

The Baltimore Sun of Sunday, April 6, ran a full-page feature about Dr. William Rush Dunton, Jr., and his recently published book, "Old Quilts." After referring to Dr. Dunton's many professional activities and achievements, the article traced the beginning of his thirty years of research in this field to his work in 1915 at a local mental hospital where he felt that the women patients benefited from the opportunity to display their skill at needlework. Dr. Dunton is currently working on two more books on quilts, one of which is to be a dictionary of quilt terms. He speaks with appreciation of the cooperation of Mrs. Dunton, his constant companion and helper.

JOINT CONFERENCE IN MICHIGAN

The program of the Spring Meeting of the Michigan Occupational Therapy Association in Detroit was most interesting. The speakers on the first day, June 6, were Dr. Louis S. Lipschutz on "New Trends in Psychiatry" and Dr. Matthew Pilling on "Plastic Surgery."

On the second day of the meeting, June 7, the Occupational Therapy Association met with the Michigan Chapter of the American Physiotherapy Association in a joint meeting in the Harper Hospital. The Morning Session, with Dr. Max Newman, Director of Physical Medicine, Grace Hospital, as Chairman, included lectures on "Cerebral Palsy" by Dr. Frederick J. Fischer, and Dr. William H. Blodgett, of the Detroit Orthopaedic Clinic. A demonstration of coordinated treatment was given by Miss Marcia G. Shaw, Physical Therapist, and Miss Antje Price, Occupational Therapist. During the afternoon session, the subject of "Psychological Elements of Poliomyelitis" was discussed by Mr. Donald M. D. Thurber, Administrator, Wayne County Chapter, National Foundation for Infantile Paralysis and Dr. Morton Seidenfield, Director of Psychological Services, National Foundation for Infantile Paralysis. Coordinated treatment demonstrations were again used to illustrate "The Technique of Physical and Occupational Therapy in the Care of the Amputee."

INDIANA TEACHERS COLLEGE OPENS NEW DIVISION

Indiana State Teachers College, Terre Haute, has opened a new "Division of Special Education," charged with a three-fold function: (1) the training of teachers, supervisors and administrators of special classes and special education divisions for public school systems, and for state schools for the seriously handicapped; (2) the training of nonmedical technicians and consultants (professional personnel other than teachers) who contribute to the education of exceptional children; and (3) the dispensation of clinical services to children and adults (both on and off campus) who have academic, psychological or sensory perception problems, or who are in need of vocational counseling for placement or adjustment.

COURSES IN HEARING, SPEECH

Western Reserve University and the Cleveland Hearing and Speech Center are holding special courses in hearing and speech therapy from June 25 to July 31, 1947. One of the courses is "Speech Correction for the Orthopedically Handicapped," given by Miss Ruth Lundin, Supervisor of Speech Correction at Cleveland Rehabilitation Center and Instructor at Western Reserve University. This course will orient physical and occupational therapists and speech teachers in organization, procedures and problems related to the orthopedically handicapped.

P. T. CONFERENCE JULY 6-12

The 1947 Conference of the American Physiotherapy Association will be held at Asilomar, Pacific Grove, California, July 6-12. For reservations write Miss Mildred Elson, Executive Secretary, American Physiotherapy Association, 1790 Broadway, New York 19, New York.

OPENS CONSULTATION OFFICE

Miss Geraldine R. Lermit, PhM., O.T.R., has opened an office for consultation in medical rehabilitation at 4633 Lindell Boulevard, St. Louis, Missouri. Miss Lermit was one of the first group of women to enter the profession of occupational therapy, and was until recently the director of the St. Louis School of Occupational Therapy.

MRS. COBB AUTHORS ARTICLE

"A Field That Knows No Employment Lag" was

an article which appeared in the November issue of The Independent Woman. It was written by Mrs. Meta Cobb, O.T.R., Executive Director of A.O.T.A., and it contains information which is useful to those who are interested in promoting occupational therapy.

NEW DIRECTORY COMPILED

A very complete and useful "Directory of Agencies and Organizations Concerned with Rehabilitation and Services to the Handicapped" has been compiled by Howard A. Rusk, M.D., and Eugene J. Taylor. It is published by the New York Times as a public service and may be obtained for ten cents. It lists eighty main groups of people operating in this field.

Among the interesting group of speakers at the Music in Therapy Institute at the University of Wisconsin, August 4, 5, 6, 1947, are Dr. Ira Altshuler of Eloise Hospital, Michigan, whose topic is "Music in Mental Hospitals" and Dr. Hans Reese of the University of Wisconsin on "Music and its Connection with Diseases of the Brain." The discussion following these presentations will be conducted by Miss Patricia A. Exton, O.T.R., of the University of Wisconsin. Miss Beatrice Wade, O.T.R., of the University of Illinois will also speak on "Music in Occupational Therapy."

The College of American Pathologist has recently been formed with F. W. Hartman, M.D., of Detroit, as President. The offices of the new organization, which has as its object the fostering of the highest standards in education, research, and practice of pathology, are at 203 North Wabash Avenue, Chicago, Illinois. Member-and-fellowship are limited to pathologists who are certified by the American Board of Pathology. It will be of especial interest to occupational therapists to note that M. G. Westmoreland, M.D., formerly member of the Council on Medical Education and Hospitals of the A.M.A., is the Executive Secretary of the new organization.

Milwaukee-Downer College is running experimentally this summer, its first post-graduate seminar for the O.T. students who took their B.S. degree last June and who have been in training throughout this year. It consists of an intensive discussion of the various areas of O.T. and culminates in a comprehensive examination before Commencement.

O. T. ITEMS

Therapists using recreational activities should be familiar with the help available to them from the National Recreation Association, 315 Fourth Ave., New York 10, N. Y., and its magazine "Recreation," published at twenty cents a copy or two dollars per year.

A two-handled file has several uses. It is constructed by screwing a C-clamp of the desired size to the "other" end of the file. In the first place, the clamp can act as an effective counter-weight for balance and resistance, especially if grasp in one hand is impaired. Secondly, the file can be held in both hands to provide bilateral or reciprocal motion. Thirdly, if impairment of mobility or control of the wrist make it difficult to hold the ordinary file-handle because of the plane in which it is situated, the file can be used by gripping the C-clamp much like a saw — for this purpose it may be necessary to pad the clamp.

Antje Price, O.T.R.

A pay telephone is a problem to any person whose skill is limited or reduced, who has only one functional hand, or who must operate from a wheel chair. Experimentation and failure are both embarrassing and costly. To give our patients an opportunity to become accustomed to handling a pay phone before having to put a real nickel in a real coin slot, we constructed a wooden model, an exact replica, which hung in a closet at the same height as the phone in the hospital's booth. We were fortunate in having a real telephone in our possession, from which we borrowed receiver and dial. We even improved on the real phone in two ways: the coins fell through the body of the replica and were immediately returned — and no impatient operator cut in.

Antje Price, O.T.R.

Our newest gadget is a very useful ceiling projector, for reading while flat in bed. The books are in the form of films (1.20-2.50 ea.), and pages are turned by the patient's pushing a button and moving the film along. Can also reverse. Manufactured by Argus Inc., Ann Arbor, Michigan. Cost after June 1, $147. Trade name: Projected Books. We like it specially for adult polios and traction patients.

BOOK REVIEWS

JOB PLACEMENT OF THE PHYSICALLY HANDICAPPED

CLARK D. BRIDGES. McGraw-Hill Book Company, 1946.

Written primarily for the plant executive who wants to employ handicapped workers, and for his personnel officer who wants to know how, this little volume of the Industrial Management Series has valuable suggestions for the occupational therapist working in the field of orthopedic disabilities.

For one thing, it gathers together concisely in the form of appendixes the work that has been done to date on evaluating disabilities as related both to daily physical activities and to job performance, by the Institute for the Crippled and Disabled in New York, and by the War Manpower Commission. It goes beyond them in providing two simple and effective check-lists to help match the items of the doctor's physical examination with the description of requirements on the job. These requirements are stated in the familiar "walking," "running," "lifting," etc., categories, qualified as to how heavy and how much.

The third and by far the largest segment of the book is devoted to a description of disabilities intended for the lay worker and divided according to the anatomical systems affected. This material is too sketchy to be of interest to the occupational therapist, but the accompanying paragraphs on placement considerations for each group are the first published material I have found which attempts to approximate these tangent fields of specialized knowledge—the medical and the industrial—for the benefit of the individual patient.

Placement is a field where for lack of exact techniques, the patient has been too often the one experimented on. The results, while sometimes excellent, have occasionally ben disastrous to morale. That we should have here a commonsense statement of specific needs shows an encouraging trend towards substituting realism for a merely charitable endeavor.

I think that as therapists we should be very careful that the dream of future employment that sustains our patients through the difficult business of getting well should also be attainable. It is as a means of sharpening our own procedures towards this end that I recommend this book. C. T.

Industrial Arts and Vocational Education. Published monthly except during July and August. $3.00 per year; single copies 35 cents. Publication Office: The Bruce Publishing Company, 540 No. Milwaukee Street, Milwaukee 1, Wisconsin.

This magazine is designated as The Shop Teachers' Professional Magazine, and contains articles of usefulness to occupational therapists. Each issue contains an article on "Testing and Tests," and gives specific methods of testing and scoring, and is of real value to the therapist in the clinical training center. The May, 1947, issue contains an article on "Inherent Therapeutic Values in Industrial Arts," and points out "some of the causes of mental-emotional deficiency; how industrial-arts subjects are used as an adjunct to the healing art of the mentally ill; therapeutic importance of industrial-arts subjects; how knowledge gained from the study of the therapeutic effectiveness of industrial arts in institutions of the mentally ill could also be used in the school industrial-arts classes."

The last section of the article explains the "Development of the Idea of Occupational Therapy," and points out the biological significance of activity, external and internal activity, the underlying drive of all living things, adaptation to the environment, and the importance of work in relation to its benefit to man's well-being.

B. J. P.

SUPPLEMENT TO UNITED STATES NAVAL MEDICAL BULLETIN

Rehabilitation at the U. S. Naval Hospital, Philadelphia. Published for the Information of the Medical Department of the Navy, March, 1946, Bureau of Medicine and Surgery, Navy Department, Washington, D. C. NAVMED 112.

For any therapist working in the general or rehabilitation fields this supplement is a must for learning the treatment of large numbers of cases of certain types of disability with every advantage of equipment and selected staffs.

The first group of papers presents the rehabilitation of the amputee; statistical analysis; types of amputation; problems of revision and reamputation; plastic and reconstructive surgery of stumps; complication; manufacture of prosthese; physical rehabilitation; emotional reactions and adjustment of amputees to their injury; amputee educational rehabilitation and prevocational training; and instruction in automobile driving.

The second group of papers presents the rehabilitation of those who have hearing or speech disorders including: the philosophy of and general approach to hearing rehabilitation; hearing loss in the Navy and Marine corps; coordination of medical and non-medical services; physical facilities and equipment for the rehabilitation of hearing; testing of hearing and fitting of hearing aids; fabrication of ear molds; speech reading, auditory training and speech correction in the re-education program; and adjustment of the hard-of-hearing after leaving the service.

The third group presents the rehabilitation of the blinded including: traumatic blindness; non-traumatic blindness; acrylic eye prostheses; re-education of the newly blinded; occupational therapy; outside orientation and physical recondition; educational and vocational counseling.

There are also two sections of neuropsychiatric re-

habilitation and the role of the Red Cross in rehabilitation.

These programs as presented will be carried out now in the civilian hospitals and veterans facilities since most of the medical officers who contributed to the program have been transferred or have returned to civilian life. With this supplement as a reference we, as therapists, may make a better contribution to the rehabilitation of our patients, and have a better understanding of the background of treatment which is given by the physician.

I. M.

THE PUPPET THEATRE HANDBOOK

MARJORIE BATCHELDER. Harper and Brothers, New York, 1947. $3.75.

Miss Batchelder has developed a technique and knowledge of puppetry which places her as one of the outstanding authorities on puppetry in the country and she has recognized the use of puppetry as a modality for occupational therapy. It is her opinion that occupational therapists should be given an opportunity to gain as much information as possible on the history of puppetry, the mechanics, the dramatics and the educational therapeutic values of puppetry.

Miss Batchelder has indeed made a contribution to occupational therapy by compiling this very useful handbook, in which the therapist will find well thought out plans on lighting, stage construction and puppet construction. The field of play-writing and the selection of plays are well treated as are the suggestions concerning the use of puppetry in occupational therapy rehabilitation, television education and as a profession. It supplies a good source of materials and a well-organized bibliography on puppetry.

S. S. B.

RHEUMATIC FEVER

Public Affairs Pamphlet No. 126, Published by Public Affairs Committee, Inc., 22 East 38th St., New York 16, N. Y. HERBERT YAHRACS, 1947.

The purpose of the committee which makes available in this summary and inexpensive form the results of research on economic and social problems is an educational one; namely to aid in the understanding and development of American policy. It has no economic or social program of its own to promote.

The American Council on Rheumatic Fever of the American Heart Association cooperated with this publication.

The manner in which it is written makes it useful for interpretation to the parents as well as to the lay persons who are working with rheumatic fever cases in the community. The graphic studies help give a clear understanding of figures and the coordination of community resources.

S. S. B.

SPEECH CORRECTION

Principles and Methods. C. VAN RIPER, Ph.D., Prentice-Hall, Inc., 1939, 434 pages, $400.

It is only recently that the general public has come to realize the seriousness of the speech defective handicap. The material in this book is well organized and clearly demonstrates how a lack of ability to communicate, can produce severe emotional reactions and a warped personality.

The work of the Speech Specialist must be supplemented by intelligent co-operation, whether it be the parent, classroom teacher, or occupational therapist, etc. It is therefore important to acquire a basic knowledge of speech correction in order to efficiently aid in an over-all program. The author, with this in mind, has gathered his material into a series of logical chapters, some of which are as follows:

Speech Handicaps and the Need for Speech Correction.
The Nature of Speech.
Recognition and Prevention of Speech Correction.
The Speech Correctionist and General Procedure in Treatment.
Treatment of the Child who has not Learned to Talk.
Treatment of the Articulatory Disorders.
Treatment of Voice Disorders.
Treatment of Stuttering.
Treatment of Cleft Palate.

A list of references will be found at the end of each chapter and will provide supplementary reading. Definitely helpful teaching techniques are described in such detail that it is easy to imagine that one is right in the classroom, listening to the lesson. A study of these methods, used in building up new speech patterns, should prove of great value to the occupational therapist who plans to devise carry-over technique in her workship.

F.M.

THERAPEUTIC EXERCISE

F. H. EWERHARDT, M.D., and GERTRUDE F. RIDDLE. Lea & Febiger, Philadelphia, 1947.

This book does not pretend to be an exhaustive text on Therapeutic Exercise. "It is the intention of the authors of this manual to provide students training in physical education, occupational therapy, and physical therapy with a manual which will be concise in content and yet will not contain too much irrelevant material." The authors chose to devote the first 5 chapters to history, analysis of joint motion, physiology of skeletal muscles and the plexuses controlling upper and lower extremities. The next chapter discusses the Relaxation Theory and Application of Fundamental Movements used in Therapeutic Exercise. Special application of Therapeutic Exercise is discussed in the next two chapters as related to postural and medical problems. The latter covers Cardiacs, Peripheral Vascular Disease, Hemiplegia, Affections of the Seventh Nerve, Arthritis, Tabes Dorsalis and Respiratory Cases. The last two chapters are devoted to Poliomyelitis and Spastic Paralysis.

The book should have value in the classroom as a basic manual with further elaboration through classroom lectures. Many teachers, however, may wish to change the emphasis and information in the manual due to more recent knowledge, particularly in the chapter on Spastic Paralysis.

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